HIGHMARK

BE READY FOR ANYTHING

Learn What You Need to Know About Your 2019 Highmark Coverage Options

Benefit Period:
January 1 to
December 31, 2019

2019 HEALTH INSURANCE

CONNECTING CARE AND COVERAGE*

You want to be ready for 2019 with the right health insurance coverage in place. At Highmark, we're here to help. That's why we've been working on new solutions that offer high-quality, easy-to-access care.

This guide contains information you need to understand your health insurance options before you enroll in a 2019 plan. That means you'll have a better idea of what to expect when you see your doctor, receive care at a hospital, or fill a prescription.

We understand that there is a lot to consider and that change can feel overwhelming at times. We hope you will use this guide to review details about our new 2019 plans and contact us with any questions you have.

Whatever 2019 has in store for you and your family, or whatever your health demands, we want you to feel ready for anything. That's why we're offering you simplified plan options with easier access to care by:

- Teaming up with doctors and hospitals in your community so you don't have to travel for care.
- Bringing care to you on your terms with virtual medicine and direct access to a Blues On Call℠ health coach who is a specially trained registered nurse.

Important Details to Consider Before Choosing a Plan:

- The open enrollment period lasts just 6 weeks.
- BlueCard® is available for emergency care and out-of-area urgent care.
- Check to see if your providers are still in network.

Choose Highmark for Your Coverage in 2019 and You'll Have:

- Peace of mind knowing your health plan is from a name trusted by generations.
- A network that includes top-rated providers right in your own community.
- Benefits including $0 copays for preventive care, such as checkups, immunizations, and much more.
- Free tools and resources to help you better manage your health and get the most from your health coverage.

*Plans may be offered by Highmark Choice Company, Highmark Health Insurance Company, or Highmark Blue Cross Blue Shield.

We're here for you if you have questions or need help along the way:

- Call **1-855-822-6927** (TTY/TDD 711)
- Visit a Highmark health insurance store
- Visit DiscoverHighmark.com
- Talk to your local insurance agent

We can also help you enroll through the Health Insurance Marketplace ("the Marketplace"). Or you can contact the Marketplace at:

- HealthCare.gov
- **1-800-318-2596** (TTY: 1-855-889-4325)

BE READY FOR ANYTHING

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BE ON TIME for Open Enrollment

OPEN ENROLLMENT PERIOD: NOVEMBER 1 TO DECEMBER 15, 2018

Mark your calendar for this year's Open Enrollment Period.

Enroll by **December 15, 2018** for coverage beginning **January 1, 2019.**

Open Enrollment is the time when you can enroll in health insurance coverage.

Enroll by **December 15** or you won't have coverage on January 1 — unless you qualify for a Special Enrollment Period.

SPECIAL ENROLLMENT PERIOD

Most people will enroll during Open Enrollment. But you can also change or enroll in coverage through a Special Enrollment Period if you have a qualifying life event. Some examples are:

- A NEW BABY
- GETTING MARRIED
- LOSING MINIMAL ESSENTIAL COVERAGE, SUCH AS COVERAGE THROUGH AN EMPLOYER
- MOVING TO A NEW, PERMANENT RESIDENCE WHERE YOU CAN'T HAVE ACCESS TO THE SAME HEALTH PLANS

If you think a Special Enrollment Period may apply to you, you can learn more by visiting **HealthCare.gov**. You may be asked to submit documents to show that you're eligible for a Special Enrollment Period.

my Direct Blue Plan Options

This year's plan options are designed with you in mind. Our new 2019 my Direct Blue plans focus on offering you high-quality care, right in your community. We've also made some changes to simplify access to health care in a way that fits better into your busy life.

To bring you top-quality care, we work with providers to create a new network that includes best-fit medical professionals and hospitals.

my Direct Blue plan options include access to Allegheny Health Network (AHN). Recognized nationally for quality care, AHN is the highest-rated health system in Western PA* for Medical Excellence in Overall Surgical Care*

Plus, services from Conemaugh Health System facilities that provide comprehensive care to western PA are in-network. Conemaugh is known for clinical excellence and is nationally recognized for patient outcomes. Conemaugh Memorial offers specialized services, including a regional Level 1 Trauma Center, Level 3 Regional Intensive Care Nursery, and high-risk obstetrical care.

Along with providing access to care close to home, finding a provider is less complicated. Doctors, facilities, and other providers are either in network or out-of-network — it's that simple.

See a list of in-network hospitals starting on page 9.

* Market claims are based on CareChex® Composite Quality Scores™ and nationally balanced scorecard criteria for health systems serving the combined statistical area (CSA) of Pittsburgh-New Castle-Weirton.

CareChex®

NEW FOR 2019

my Direct Blue PLAN OPTIONS

my Direct Blue makes it easy to get the care you need with in-network providers. You'll have access to a network of quality doctors and hospitals based in the community.

With some Direct Blue plans, you get:

- $0 copay for your first two PCP office visits*
- $0 copay for your first two mental health visits*
- $0 copay for your first two substance abuse office visits*
- $0 preventive screens, routine wellness exams, immunizations, and vaccinations
- More services that can be paid with a simple copay
- No referrals to see a specialist

*The availability of $0 copay visits and the type of visits (PCP, mental health, and/or substance abuse) are dependent upon the plan selected.

BE WELL-INFORMED for Simpler Health Plans

Major Events/Catastrophic Coverage

If you are under 30 or meet financial hardship requirements, the lower-cost Major Events plan may be for you. It provides the protection you need in case of an emergency, serious illness, or accident. Plus, your first three visits to your primary care doctor — and certain preventive services — are covered at no cost.

Qualified High Deductible Health Plan Advantages

Highmark also offers qualified high deductible plans that may be coupled with a Health Savings Account (HSA). Other than preventive care, you will pay most costs until your deductible is met. After that, Highmark pays for most covered in-network care for the remainder of the benefit period. 2019 plans are available at the Silver metal level.

Highmark Blue Edge Dental

Do you need adult dental insurance?
Visit HighmarkBlueEdgeDental.com to find out more.

BE WELL-INFORMED for Simpler Health Plans

IN AN EMERGENCY, YOU'RE COVERED!

Your health matters to us. We know medical emergencies happen, and you can rest easy knowing that you're covered — whether you are home or traveling. But there are some important things that you should know when receiving non-emergency services under Highmark's my Direct Blue plans.*

Out-of-Network Care is available only for Emergencies and Urgent Care when outside of your plan's service area.

my Direct Blue plans include out-of-network care for emergencies and out of area urgent care. In a medical emergency, call 911 or go immediately to the nearest emergency room. If in-patient hospital care is required, Highmark will work with the treating physician and hospital to transfer you or your family to an in-network facility once your condition is stable.

Out-of-Area BlueCard Coverage

BlueCard coverage is available only for emergency and urgent care when you are away from home. Non-emergent care is not covered. If you seek care out of the my Direct Blue service area for a non-emergent condition, you are responsible for all costs associated with that care.

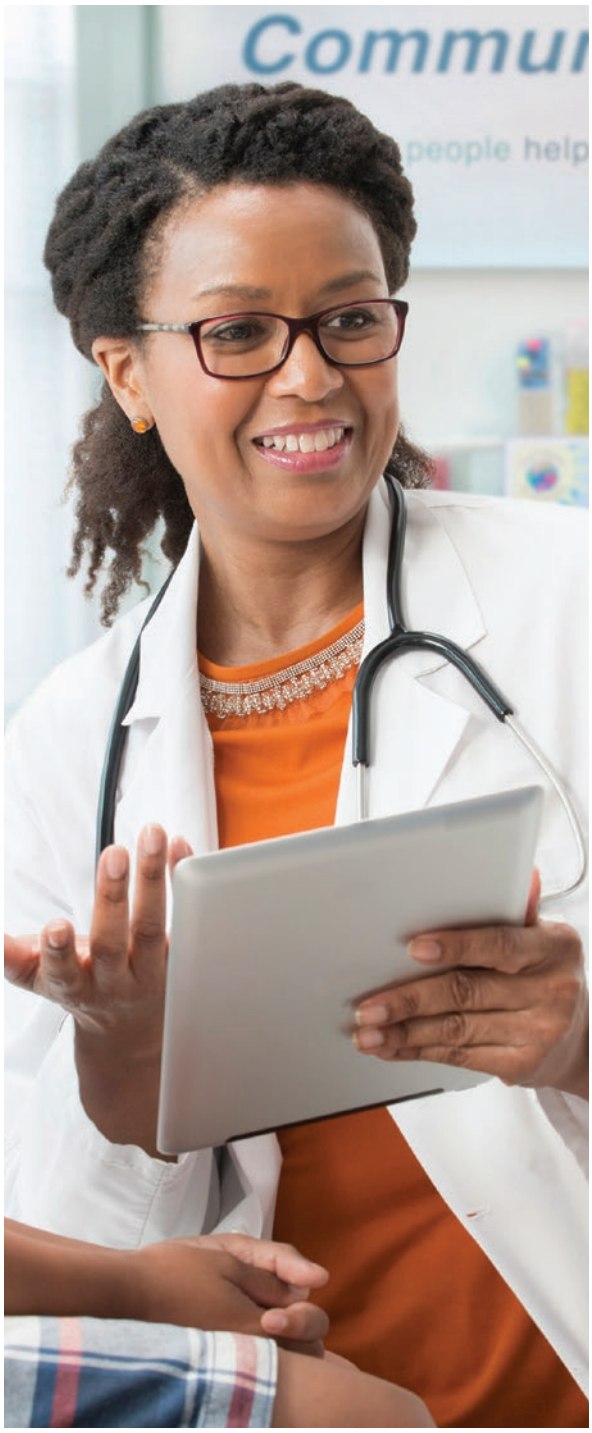
UPMC Consent Decree Does NOT Apply to my Direct Blue Plans

Coverage for most UPMC providers and facilities is not included with my Direct Blue plans, including receiving care from a UPMC provider and/or at a UPMC facility under the protections of the Consent Decree. my Direct Blue members will need to transition care to an in-network provider or facility.

The Children's Hospital of Pittsburgh of UPMC remains in-network for all plans.

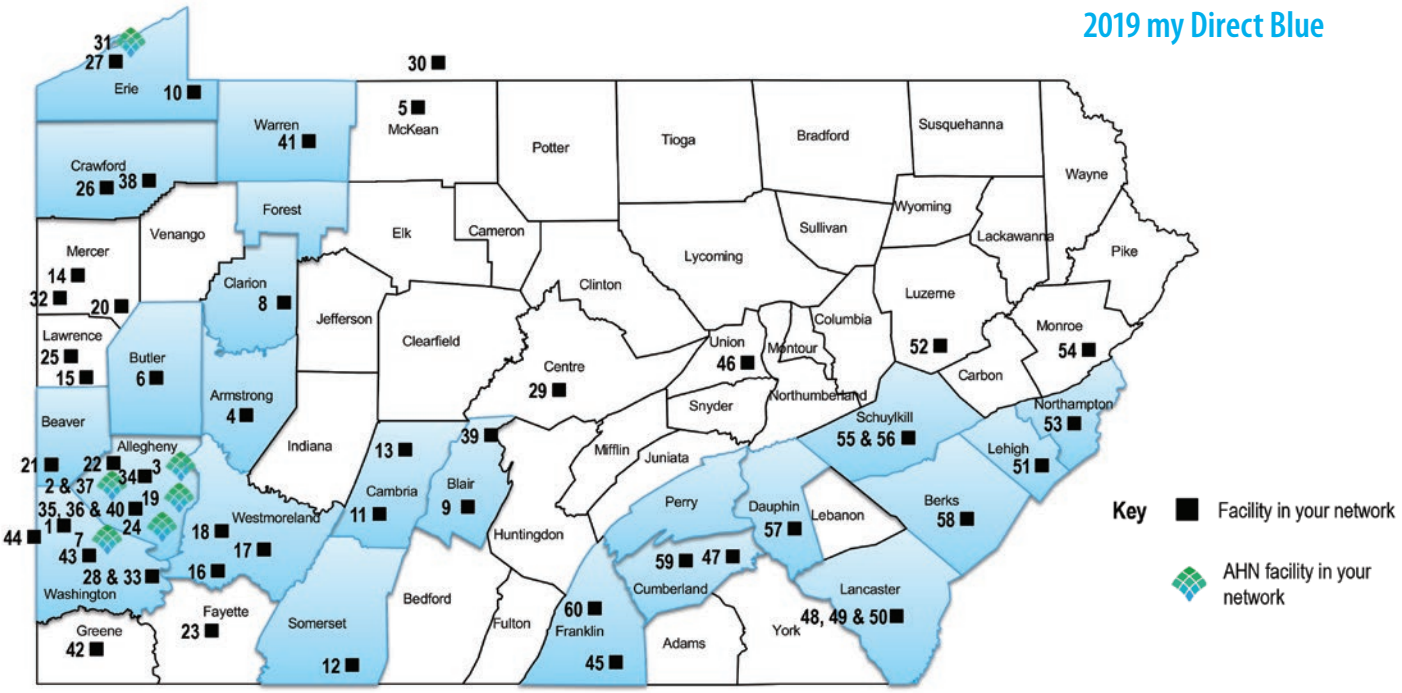
REMINDER

It's a good idea to check the status of the provider or facility that you are visiting before you make an appointment. If an out-of-network provider or facility is selected for non-emergency care, you are responsible for all costs associated with that care.



**Highmark also offers PPO plans. Health care plans are subject to terms of your benefit agreement.*

BE WELL-INFORMED Find a Network Hospital



Facility ID	County	Facility Name
1	Washington	Advanced Surgical Hospital
2	Allegheny	Allegheny General Hospital
3	Allegheny	Allegheny Valley Hospital
4	Armstrong	Armstrong County Memorial Hospital
5	McKean	Bradford Regional Medical Center
6	Butler	Butler Memorial Hospital
7	Washington	Canonsburg General Hospital
8	Clarion	Clarion Hospital
9	Blair	Conemaugh Nason Medical Center
10	Erie	Corry Memorial Hospital
11	Cambria	Dlp Conemaugh Memorial Medical Center
12	Somerset	Dlp Conemaugh Meyersdale Medical Center
13	Cambria	Dlp Conemaugh Miners Medical Center
14	Mercer	Edgewood Surgical Hospital
15	Lawrence	Ellwood City Hospital
16	Westmoreland	Excela Health Frick Hospital
17	Westmoreland	Excela Health Latrobe Hospital
18	Westmoreland	Excela Health Westmoreland Hospital
19	Allegheny	Forbes Regional Hospital
20	Mercer	Grove City Medical Center
21	Beaver	Heritage Valley Beaver
22	Allegheny	Heritage Valley Sewickley
23	Fayette	Highlands Hospital
24	Allegheny	Jefferson Regional Medical Center
25	Lawrence	Lawrence County Surgery Center of Edgewood Surgical Hospital
26	Crawford	Meadville Medical Center
27	Erie	Millcreek Community Hospital
28	Washington	Monongahela Valley Hospital
29	Centre	Mount Nittany Medical Center
30	Cattaraugus, NY	Olean General Hospital

Facility ID	County	Facility Name
31	Erie	Saint Vincent Health Center
32	Mercer	Sharon Regional Medical Center
33	Washington	Spartan Health Surgicenter
34	Allegheny	St. Clair Hospital
35	Allegheny	The Children's Home of Pittsburgh & Lemieux Family Center
36	Allegheny	The Children's Institute
37	Allegheny	The Western Pennsylvania Hospital
38	Crawford	Titusville Area Hospital
39	Blair	Tyrone Hospital
40	Allegheny	UPMC Children's Hospital of Pittsburgh
41	Warren	Warren General Hospital
42	Greene	Washington Health System – Greene
43	Washington	Washington Hospital
44	Hancock, WV	Weirton Medical Center
45	Franklin	Chambersburg Hospital
46	Union	Evangelical Community Hospital
47	Cumberland	Geisinger Holy Spirit Hospital
48	Lancaster	Lancaster General Hospital
49	Lancaster	Lancaster General Hospital Women & Babies
50	Lancaster	Lancaster Surgery Center
51	Lehigh	Lehigh Valley Hospital
52	Luzerne	Lehigh Valley Hospital – Hazleton
53	Northampton	Lehigh Valley Hospital – Muhlenberg
54	Monroe	Lehigh Valley Hospital – Pocono
55	Schuylkill	Lehigh Valley Hospital - Schuylkill E. Norwegian Street
56	Schuylkill	Lehigh Valley Hospital - Schuylkill S. Jackson Street
57	Dauphin	Penn State Health Milton S. Hershey Medical Center
58	Berks	Penn State Health St. Joseph Medical Center
59	Cumberland	UPMC Pinnacle Carlisle
60	Franklin	Waynesboro Hospital

AHN facility in your network

For 2019, we're teaming up with hospitals and medical professionals in your backyard and across Pennsylvania to deliver high-quality care.

*Network provider list as of September 2018. Please refer to the online Find a Doctor tool at **HighmarkBCBS.com** for a listing of network hospitals.

BE WELL-INFORMED Choose a Network Primary Care Provider

Get More From my Direct Blue — Choose an In-Network Primary Care Provider (PCP)

Even when you're healthy, having an in-network PCP feels great. A PCP is the doctor, medical professional, or practice that you visit for your primary and routine health care services, such as physicals and immunizations. The Journal of Health Affairs has found that people with PCPs enjoy lower overall health care costs and higher satisfaction with their care.

A PCP Can Help You:

- Get the most value from your health care dollar.
- Achieve health goals.
- Monitor chronic health conditions .
- Make sure you receive preventive care, like annual exams.
- Coordinate the care you receive from other providers, such as specialists, labs, and imaging centers, to prevent gaps or overlaps in service.
- Improve your patient experience.

HMO PLANS ONLY

Please be aware that if you select a Highmark my Direct Blue HMO (Health Maintenance Organization) plan and do not choose a PCP, one will be assigned to you. You can change your PCP at any time.

How to Find Out if Your Provider is In-Network: 3 Easy Ways

Doctors, hospitals, and pharmacies in networks often change. That's why it is very important to make sure your provider and/or facility are in-network before choosing an insurance plan. That way, you'll help avoid surprises — and unexpected costs.

If you go to an out-of-network doctor, pharmacy, hospital, or other provider, you will have to pay 100% of the cost, except in the case of emergency or out-of-area urgent care.

1 Find a Doctor or Rx

It's quick and easy to find an in-network provider or facility. Search online by plan type to make sure your doctor, specialist, or hospital is in-network. See maps, office hours, quality ratings, member reviews, and more. Visit HighmarkBCBS.com and click **Find a Doctor or Rx** to get started.

It's easy to check which prescribed drugs are covered under your 2019 insurance plan. View Highmark's online Rx drug listing (or formulary) at HighmarkBCBS.com and click **Find a Doctor or Rx.**

BE WELL-INFORMED Review Your Prescription Drug List

2 My Care Navigator

Is your doctor in-network? My Care Navigator health advocates make it easy for you to find or change to an in-network doctor or facility, schedule an appointment, and transfer your medical records. Call **1-888-BLUE-428** or visit MyCareNavigator.com.

3 Highmark Member Service

Already a Highmark member? You probably know the value of great customer service from our Member Service area. By calling the number on the back of your Highmark ID card, our dedicated team can help find you an in-network doctor or facility.

2019 Prescription Drug List

Prescription drugs are an important part of your coverage. The list of the drugs that your plan covers is called a "formulary."

As you choose a plan for 2019, be well-informed to help avoid surprises. Be sure to check to see if your prescription drugs will be covered.

Highmark plans use the Essential Formulary, which groups drugs into four levels or "tiers." Each tier may include generic, brand-name, and/or specialty drugs. If your doctor prescribes a drug that is not included in the Essential Formulary, you may have to pay 100% out of pocket, unless an extension is granted.

It's easy to check how your prescription drugs are covered — visit HighmarkEssentialFormulary.com.

Essential Formulary – 4 Tiers of Drugs

Tier 1	Tier 2	Tier 3	Tier 4
Low-Cost Generics	Medium-Cost Generics & Low-Cost Brands	High-Cost Generics & Medium/High-Cost Brands	High-Cost Generics & High-Cost Brands

BE PREPARED Before You Choose

Ask yourself these important questions before choosing a plan!

- Is my doctor in-network?
- Is my hospital in-network?
- At what tier are my prescription drugs covered and how much will they cost?
- Can I get financial help through the Marketplace?
- Would I rather have lower monthly premiums or lower copays?
- Should I open a Health Savings Account (HSA) to manage out-of-pocket costs with a qualified high deductible health plan?

Highmark offers you the support you need to answer these questions and more. We want you to have the plan that works best for your needs — so you can be ready for anything.

Metal Levels and Essential Health Benefits

When you are shopping for one of Highmark's Affordable Care Act (ACA) health insurance plans, it's important to know about metal levels and essential health benefits.

Metal Levels

Highmark's ACA health plans are grouped in metal categories: Bronze, Silver, and Gold. These levels are based on how you and your health plan split the costs of your health care. They are simply ways to categorize plan payment levels. **They do not describe the quality of care you receive.**

Essential Health Benefits

All Highmark ACA plans include these essential health benefits:

- Ambulatory services, such as primary care and specialist visits
- Maternity and newborn care
- Emergency services
- Prescription drugs, including retail and mail order
- Pediatric services, including dental and vision care
- Mental health and substance abuse services
- Rehabilitative and habilitative services and devices
- Hospitalization
- Laboratory services
- Preventive and wellness services, and chronic disease management

BE PREPARED Before You Choose

You May Qualify for Financial Help. It's Easy to Check.

Most people who buy insurance through the Marketplace are pleased to learn they can get help paying for insurance. Before you enroll, you should find out if you can get this help to lower the cost of your monthly premium. To start, check the 2019 Household Income Chart below.

You may qualify for one or both kinds of financial help:

- Advanced Premium Tax Credits (APTC), which may be applied — in advance — to lower what you pay each month for your premium on any Marketplace metal-level plan.
- Cost-Sharing Reductions (CSR)* will lower out-of-pocket costs that you may pay at the time of service for doctor visits, lab tests, drugs, and other covered services. You can only get these savings if you enroll in a Marketplace Silver metal-level plan.

Eligibility for financial help can only be determined through the Marketplace at **HealthCare.gov**.

2019 Household Income	Persons In Family / Household							
	1	2	3	4	5	6	7	8
Cost-Sharing Reductions (CSR)	$12,140 – $30,350	$16,460 – $41,150	$20,780 – $51,950	$25,100 – $62,750	$29,420 – $73,550	$33,740 – $84,350	$38,060 – $95,150	$42,380 – $105,950
Advanced Premium Tax Credits (APTC)	$12,140 – $48,560	$16,460 – $65,840	$20,780 – $83,120	$25,100 – $100,400	$29,420 – $117,680	$33,740 – $134,960	$38,060 – $152,240	$42,380 – $169,520
Medicaid Eligible Range (100–138% or less FPL)	$12,140 – $16,753	$16,460 – $22,715	$20,780 – $28,676	$25,100 – $34,638	$29,420 – $40,600	$33,740 – $46,561	$38,060 – $52,523	$42,380 – $58,484

This chart is only applicable for coverage in 2019 and in the 48 contiguous states and the District of Columbia. For families/households with more than 8 persons, add $4,180 for each additional person. HHS Poverty Guidelines for 2018 (January 31, 2018). Retrieved from https://aspe.hhs.gov/poverty-guidelines 10-25-18.

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

You'll need these documents for yourself and every family member you want to enroll:

- Social Security numbers (or documents for legal immigrants)
- Birth dates
- Pay stubs, W-2 forms, or wage and tax statements — to determine your income
- Policy numbers for any current health insurance
- Information about any health insurance you or your family could get from your job

2019 PLAN BENEFIT GRIDS

There's a lot to know and do when it comes to picking the right plan for you and your family.

If you are looking for more medical plan details, visit Highmark-SBC2019.com to find each plan's Summary of Benefits and Coverage. If you do not have online access, you can get a paper copy of any Summary of Benefits free of charge by calling Highmark toll-free **1-855-822-6927 (TTY/TDD 711).**

Counties Plan Available In: Allegheny, Washington, and Westmoreland

my Direct Blue HMO Bronze 7900 **BRONZE**

On-Exchange Base Plan ID: 38949PA0080008-01 **Off-Exchange Base Plan ID: 38949PA0080008-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$7,900	No Coverage
Deductible-Aggregate (Family)	$15,800	
Out of Pocket Maximum (Individual)	$7,900	
Out of Pocket Maximum- Aggregate (Family)	$15,800	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	0% after deductible	No Coverage
Specialist Office & Virtual Visits	0% after deductible	
Outpatient Mental Health Visits	0% first 2 visits then 0% after deductible	
Telemedicine Service	0% after deductible	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	0% after deductible	No Coverage
Hospital Outpatient	0% after deductible	
Inpatient Hospital Maternity	0% after deductible	
Medical Care and Surgical Expenses	0% after deductible	
Emergency Services		
Urgent Care Center Visits	0% after deductible	0% after deductible
Emergency Room Services	0% after deductible	0% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	0% after deductible	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	0% after deductible	
Chiropractor Services	0% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	0% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	0% after deductible	
Lab/Pathology	0% after deductible	

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	0% after deductible	0% after deductible	0% after deductible	0% after deductible
Prescription Drug Coverage Mail (90 days supply)	0% after deductible	0% after deductible	0% after deductible	0% after deductible

Counties Plan Available In: Allegheny, Washington, and Westmoreland

my Direct Blue HMO Bronze 4000 **BRONZE**

On-Exchange Base Plan ID: 38949PA0080007-01 **Off-Exchange Base Plan ID: 38949PA0080007-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$4,000	No Coverage
Deductible-Aggregate (Family)	$8,000	
Out of Pocket Maximum (Individual)	$7,900	
Out of Pocket Maximum (Family)	$15,800	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$60 copay	No Coverage
Specialist Office & Virtual Visits	30% after deductible	
Outpatient Mental Health Visits	0% first 2 visits then 30% after deductible	
Telemedicine Service	$25 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	30% after deductible	30% after deductible
Emergency Room Services	30% after deductible	30% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	30% after deductible	No Coverage
Speech Therapy (Rehabilitative and Habilitative)	30% after deductible	
Chiropractor Services	30% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	30% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	30% after deductible	
Prescription Drugs		
Formulary- Essential (Drug List)		

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Prescription Drug Coverage Mail (90 days supply)	30% after deductible	30% after deductible	30% after deductible	30% after deductible

Counties Plan Available In: Allegheny, Washington, and Westmoreland

my Direct Blue HMO Silver 4450 HSA **SILVER**

On-Exchange Base Plan ID: 38949PA0090001-01 **Off-Exchange Base Plan ID: 38949PA0090001-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$4,450	No Coverage
Deductible-Embedded (Family)	$8,900	
Out of Pocket Maximum (Individual)	$6,650	
Out of Pocket Maximum- Embedded (Family)	$13,300	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	10% after deductible	No Coverage
Specialist Office & Virtual Visits	10% after deductible	
Outpatient Mental Health Visits	10% after deductible	
Telemedicine Service	10% after deductible	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	10% after deductible	No Coverage
Hospital Outpatient	10% after deductible	
Inpatient Hospital Maternity	10% after deductible	
Medical Care and Surgical Expenses	10% after deductible	
Emergency Services		
Urgent Care Center Visits	10% after deductible	10% after deductible
Emergency Room Services	10% after deductible	10% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	10% after deductible	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	10% after deductible	
Chiropractor Services	10% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	10% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	10% after deductible	
Lab/Pathology	10% after deductible	

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Prescription Drug Coverage Mail (90 days supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible

Counties Plan Available In: Allegheny, Washington, and Westmoreland

my Direct Blue HMO Silver 2400 - 2 Free PCP Visits — SILVER

On-Exchange Base Plan ID: 38949PA0080002-01 Off-Exchange Base Plan ID: 38949PA0080002-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$2,400	No Coverage
Deductible-Aggregate (Family)	$4,800	
Out of Pocket Maximum (Individual)	$7,800	
Out of Pocket Maximum- Aggregate (Family)	$15,600	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $40 copay	No Coverage
Specialist Office & Virtual Visits	$90 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $90 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	$90 copay	$90 copay
Emergency Room Services *(Copay Waived if Admitted)*	$750 copay after deductible	$750 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	$90 copay	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	$90 copay	
Chiropractor Services	$90 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$90 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	$50 copay	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min / $1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min / $2,000 Max)

Counties Plan Available In: Allegheny, Washington, and Westmoreland

my Direct Blue HMO Silver 0 — SILVER

On-Exchange Base Plan ID: 38949PA0080009-01 Off-Exchange Base Plan ID: 38949PA0080009-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$0	No Coverage
Deductible-Aggregate (Family)	$0	
Out of Pocket Maximum (Individual)	$7,800	
Out of Pocket Maximum- Aggregate (Family)	$15,600	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$40 copay	No Coverage
Specialist Office & Virtual Visits	$90 copay	
Outpatient Mental Health Visits	$0 copay first 2 visits then $90 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	$3,900 copay per day (Two Day Max)	No Coverage
Hospital Outpatient	40%	
Inpatient Hospital Maternity	$3,900 copay per day (Two Day Max)	
Medical Care and Surgical Expenses	40%	
Emergency Services		
Urgent Care Center Visits	$90 copay	$90 copay
Emergency Room Services *(Copay Waived if Admitted)*	$1,400 copay	$1,400 copay
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	$90 copay	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	$90 copay	
Chiropractor Services	$90 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$90 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	40%	
Lab/Pathology	$30 copay	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min/$2,000 Max)

Counties Plan Available In: Allegheny, Washington, and Westmoreland

my Direct Blue HMO Gold 1000 - 2 Free PCP Visits — GOLD

On-Exchange Base Plan ID: 38949PA0080001-01 **Off Exchange Base Plan ID: 38949PA0080001-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$1,000	No Coverage
Deductible-Aggregate (Family)	$2,000	
Out of Pocket Maximum (Individual)	$7,000	
Out of Pocket Maximum- Aggregate (Family)	$14,000	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $20 copay	No Coverage
Specialist Office & Virtual Visits	$45 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $45 copay	
Telemedicine Service	$15 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	20% after deductible	No Coverage
Hospital Outpatient	20% after deductible	
Inpatient Hospital Maternity	20% after deductible	
Medical Care and Surgical Expenses	20% after deductible	
Emergency Services		
Urgent Care Center Visits	$45 copay	$45 copay
Emergency Room Services *(Copay Waived if Admitted)*	$500 copay after deductible	$500 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	$45 copay	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	$45 copay	
Chiropractor Services	$45 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$50 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	20% after deductible	
Lab/Pathology	$20 copay	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min/$2,000 Max)

Counties Plan Available In: Erie

my Direct Blue ERIE HMO Bronze 7900 BRONZE

On-Exchange Base Plan ID: 38949PA0100002-01 Off-Exchange Base Plan ID: 38949PA0100002-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$7,900	No Coverage
Deductible-Aggregate (Family)	$15,800	
Out of Pocket Maximum (Individual)	$7,900	
Out of Pocket Maximum- Aggregate (Family)	$15,800	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	0% after deductible	No Coverage
Specialist Office & Virtual Visits	0% after deductible	
Outpatient Mental Health Visits	0% first 2 visits then 0% after deductible	
Telemedicine Service	0% after deductible	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	0% after deductible	No Coverage
Hospital Outpatient	0% after deductible	
Inpatient Hospital Maternity	0% after deductible	
Medical Care and Surgical Expenses	0% after deductible	
Emergency Services		
Urgent Care Center Visits	0% after deductible	0% after deductible
Emergency Room Services	0% after deductible	0% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	0% after deductible	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	0% after deductible	
Chiropractor Services	0% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	0% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	0% after deductible	
Lab/Pathology	0% after deductible	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	0% after deductible	0% after deductible	0% after deductible	0% after deductible
Prescription Drug Coverage Mail (90 days supply)	0% after deductible	0% after deductible	0% after deductible	0% after deductible

Counties Plan Available In: Erie

my Direct Blue ERIE HMO Bronze 4000 — BRONZE

On-Exchange Base Plan ID: 38949PA0100001-01 **Off-Exchange Base Plan ID: 38949PA0100001-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$4,000	No Coverage
Deductible-Aggregate (Family)	$8,000	
Out of Pocket Maximum (Individual)	$7,900	
Out of Pocket Maximum- Aggregate (Family)	$15,800	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$60 copay	No Coverage
Specialist Office & Virtual Visits	30% after deductible	
Outpatient Mental Health Visits	0% first 2 visits then 30% after deductible	
Telemedicine Service	$25 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	30% after deductible	30% after deductible
Emergency Room Services	30% after deductible	30% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	30% after deductible	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	30% after deductible	
Chiropractor Services	30% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	30% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	30% after deductible	
Prescription Drugs		
Formulary- Essential (Drug List)		

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Prescription Drug Coverage Mail (90 days supply)	30% after deductible	30% after deductible	30% after deductible	30% after deductible

Counties Plan Available In: Erie

my Direct Blue ERIE HMO Silver 4450 HSA — SILVER

On-Exchange Base Plan ID: 38949PA0110001-01 — Off-Exchange Base Plan ID: 38949PA0110001-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$4,450	No Coverage
Deductible-Embedded (Family)	$8,900	
Out of Pocket Maximum (Individual)	$6,650	
Out of Pocket Maximum- Embedded (Family)	$13,300	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	10% after deductible	No Coverage
Specialist Office & Virtual Visits	10% after deductible	
Outpatient Mental Health Visits	10% after deductible	
Telemedicine Service	10% after deductible	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	10% after deductible	No Coverage
Hospital Outpatient	10% after deductible	
Inpatient Hospital Maternity	10% after deductible	
Medical Care and Surgical Expenses	10% after deductible	
Emergency Services		
Urgent Care Center Visits	10% after deductible	10% after deductible
Emergency Room Services	10% after deductible	10% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	10% after deductible	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	10% after deductible	
Chiropractor Services	10% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	10% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	10% after deductible	
Lab/Pathology	10% after deductible	
Prescription Drugs		
Formulary- Essential (Drug List)		

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Prescription Drug Coverage Mail (90 days supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible

Counties Plan Available In: Erie

my Direct Blue ERIE HMO Silver 2400 - 2 Free PCP Visits — SILVER

On-Exchange Base Plan ID: 38949PA0100003-01 **Off-Exchange Base Plan ID: 38949PA0100003-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$2,400	No Coverage
Deductible-Aggregate (Family)	$4,800	
Out of Pocket Maximum (Individual)	$7,800	
Out of Pocket Maximum- Aggregate (Family)	$15,600	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $40 copay	No Coverage
Specialist Office & Virtual Visits	$90 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $90 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	$90 copay	$90 copay
Emergency Room Services *(Copay Waived if Admitted)*	$750 copay after deductible	$750 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	$90 copay	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	$90 copay	
Chiropractor Services	$90 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$90 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	$50 copay	

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min / $1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min / $2,000 Max)

Counties Plan Available In: Erie

my Direct Blue ERIE HMO Silver 0 — **SILVER**

On-Exchange Base Plan ID: 38949PA0100004-01 — **Off-Exchange Base Plan ID: 38949PA0100004-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$0	No Coverage
Deductible-Aggregate (Family)	$0	
Out of Pocket Maximum (Individual)	$7,800	
Out of Pocket Maximum- Aggregate (Family)	$15,600	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$40 copay	No Coverage
Specialist Office & Virtual Visits	$90 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $90 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	$3,900 copay per day (Two Day Max)	No Coverage
Hospital Outpatient	40%	
Inpatient Hospital Maternity	$3,900 copay per day (Two Day Max)	
Medical Care and Surgical Expenses	40%	
Emergency Services		
Urgent Care Center Visits	$90 copay	$90 copay
Emergency Room Services *(Copay Waived if Admitted)*	$1,400 copay	$1,400 copay
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	$90 copay	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	$90 copay	
Chiropractor Services	$90 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$90 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	40%	
Lab/Pathology	$30 copay	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35%	50% ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35%	50% ($500 Min/$2,000 Max)

Counties Plan Available In: Erie

my Direct Blue ERIE HMO Gold 1000 - 2 Free PCP Visits — GOLD

On-Exchange Base Plan ID: 38949PA0100006-01 **Off-Exchange Base Plan ID: 38949PA0100006-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$1,000	No Coverage
Deductible-Aggregate (Family)	$2,000	
Out of Pocket Maximum (Individual)	$7,000	
Out of Pocket Maximum- Aggregate (Family)	$14,000	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $20 copay	No Coverage
Specialist Office & Virtual Visits	$45 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $45 copay	
Telemedicine Service	$15 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	20% after deductible	No Coverage
Hospital Outpatient	20% after deductible	
Inpatient Hospital Maternity	20% after deductible	
Medical Care and Surgical Expenses	20% after deductible	
Emergency Services		
Urgent Care Center Visits	$45 copay	$45 copay
Emergency Room Services *(Copay Waived if Admitted)*	$500 copay after deductible	$500 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	$45 copay	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	$45 copay	
Chiropractor Services	$45 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$50 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	20% after deductible	
Lab/Pathology	$20 copay	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min/$2,000 Max)

Counties Plan Available In: Armstrong, Beaver, Butler, Clarion, Crawford, Forest, Warren

Major Events Blue PPO, a Community Blue Plan 7900 **CATASTROPHIC**

On-Exchange Base Plan ID: 33709PA0380004-01 **Off-Exchange Base Plan ID: 33709PA0380004-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$7,900	$15,800
Deductible-Aggregate (Family)	$15,800	$31,600
Out of Pocket Maximum (Individual)	$7,900	$15,800
Out of Pocket Maximum (Family)	$15,800	$31,600
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	0% first 3 visits then 0% After Deductible	0% After Deductible
Specialist Office & Virtual Visits	0% After Deductible	0% After Deductible
Outpatient Mental Health Visits	0% After Deductible	0% After Deductible
Telemedicine Service	0% After Deductible	No Coverage
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	0% After Deductible	0% After Deductible
Hospital Outpatient	0% After Deductible	0% After Deductible
Inpatient Hospital Maternity	0% After Deductible	0% After Deductible
Medical Care and Surgical Expenses	0% After Deductible	0% After Deductible
Emergency Services		
Urgent Care Center Visits	0% After Deductible	0% After Deductible
Emergency Room Services	0% After Deductible	0% After Deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	0% After Deductible	0% After Deductible
Speech Therapy (Rehabilitative and Habilitative)	0% After Deductible	0% After Deductible
Chiropractor Services	0% After Deductible	0% After Deductible
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	0% After Deductible	0% After Deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	0% After Deductible	0% After Deductible
Lab/Pathology	0% After Deductible	0% After Deductible
Prescription Drugs		

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	0% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible
Prescription Drug Coverage Mail (90 days supply)	0% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible

Counties Plan Available In: Armstrong, Beaver, Butler, Clarion, Crawford, Forest, Warren

my Direct Blue EPO Bronze 7900 **BRONZE**

On-Exchange Base Plan ID: 33709PA0870008-01 **Off-Exchange Base Plan ID: 33709PA0870008-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductibles and Out-of-Pocket Costs		
Deductible (Individual)	$7,900	No Coverage
Deductible-Aggregate (Family)	$15,800	
Out of Pocket Maximum (Individual)	$7,900	
Out of Pocket Maximum- Aggregate (Family)	$15,800	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	0% after deductible	No Coverage
Specialist Office & Virtual Visits	0% after deductible	
Outpatient Mental Health Visits	0% first 2 visits then 0% after deductible	
Telemedicine Service	0% after deductible	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	0% after deductible	No Coverage
Hospital Outpatient	0% after deductible	
Inpatient Hospital Maternity	0% after deductible	
Medical Care and Surgical Expenses	0% after deductible	
Emergency Services		
Urgent Care Center Visits	0% after deductible	0% after deductible
Emergency Room Services	0% after deductible	0% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	0% after deductible	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	0% after deductible	
Chiropractor Services	0% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	0% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	0% after deductible	
Lab/Pathology	0% after deductible	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	0% after deductible	0% after deductible	0% after deductible	0% after deductible
Prescription Drug Coverage Mail (90 days supply)	0% after deductible	0% after deductible	0% after deductible	0% after deductible

Counties Plan Available In: Armstrong, Beaver, Butler, Clarion, Crawford, Forest, Warren

my Direct Blue EPO Bronze 4000 **BRONZE**

On-Exchange Base Plan ID: 33709PA0870007-01 **Off-Exchange Base Plan ID: 33709PA0870007-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$4,000	No Coverage
Deductible-Aggregate (Family)	$8,000	
Out of Pocket Maximum (Individual)	$7,900	
Out of Pocket Maximum- Aggregate (Family)	$15,800	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$60 copay	No Coverage
Specialist Office & Virtual Visits	30% after deductible	
Outpatient Mental Health Visits	0% first 2 visits then 30% after deductible	
Telemedicine Service	$25 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	30% after deductible	30% after deductible
Emergency Room Services	30% after deductible	30% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	30% after deductible	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	30% after deductible	
Chiropractor Services	30% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	30% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	30% after deductible	
Prescription Drugs		
Formulary- Essential (Drug List)		

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Prescription Drug Coverage Mail (90 days supply)	30% after deductible	30% after deductible	30% after deductible	30% after deductible

Counties Plan Available In: Armstrong, Beaver, Butler, Clarion, Crawford, Forest, Warren

my Direct Blue EPO Silver 4450 HSA **SILVER**

On-Exchange Base Plan ID: 33709PA0890001-01 **Off-Exchange Base Plan ID: 33709PA0890001-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$4,450	No Coverage
Deductible-Embedded (Family)	$8,900	
Out of Pocket Maximum (Individual)	$6,650	
Out of Pocket Maximum- Embedded (Family)	$13,300	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	10% after deductible	No Coverage
Specialist Office & Virtual Visits	10% after deductible	
Outpatient Mental Health Visits	10% after deductible	
Telemedicine Service	10% after deductible	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	10% after deductible	No Coverage
Hospital Outpatient	10% after deductible	
Inpatient Hospital Maternity	10% after deductible	
Medical Care and Surgical Expenses	10% after deductible	
Emergency Services		
Urgent Care Center Visits	10% after deductible	10% after deductible
Emergency Room Services	10% after deductible	10% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	10% after deductible	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	10% after deductible	
Chiropractor Services	10% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	10% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	10% after deductible	
Lab/Pathology	10% after deductible	

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
Prescription Drug Coverage Retail (31 days supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Prescription Drug Coverage Mail (90 days supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible

Counties Plan Available In: Armstrong, Beaver, Butler, Clarion, Crawford, Forest, Warren

my Direct Blue EPO Silver 2400 - 2 Free PCP Visits — SILVER

On-Exchange Base Plan ID: 33709PA0870002-01 **Off-Exchange Base Plan ID: 33709PA0870002-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$2,400	No Coverage
Deductible-Aggregate (Family)	$4,800	
Out of Pocket Maximum (Individual)	$7,800	
Out of Pocket Maximum- Aggregate (Family)	$15,600	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $40 copay	No Coverage
Specialist Office & Virtual Visits	$90 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $90 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	$90 copay	$90 copay
Emergency Room Services *(Copay Waived if Admitted)*	$750 copay after deductible	$750 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	$90 copay	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	$90 copay	
Chiropractor Services	$90 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$90 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	$55 copay	

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min / $1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min / $2,000 Max)

Counties Plan Available In: Armstrong, Beaver, Butler, Clarion, Crawford, Forest, Warren

my Direct Blue EPO Silver 0 **SILVER**

On-Exchange Base Plan ID: 33709PA0870009-01 **Off-Exchange Base Plan ID: 33709PA0870009-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$0	No Coverage
Deductible-Aggregate (Family)	$0	
Out of Pocket Maximum (Individual)	$7,800	
Out of Pocket Maximum- Aggregate (Family)	$15,600	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$40 copay	No Coverage
Specialist Office & Virtual Visits	$90 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $90 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	$3,900 copay per day (Two Day Max)	No Coverage
Hospital Outpatient	40%	
Inpatient Hospital Maternity	$3,900 copay per day (Two Day Max)	
Medical Care and Surgical Expenses	40%	
Emergency Services		
Urgent Care Center Visits	$90 copay	$90 copay
Emergency Room Services *(Copay Waived if Admitted)*	$1,400 copay	$1,400 copay
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	$90 copay	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	$90 copay	
Chiropractor Services	$90 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$90 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	40%	
Lab/Pathology	$45 copay	

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min/$2,000 Max)

Counties Plan Available In: Armstrong, Beaver, Butler, Clarion, Crawford, Forest, Warren

my Direct Blue EPO Gold 1000 - 2 Free PCP Visits — GOLD

On-Exchange Base Plan ID: 33709PA0870001-01 **Off-Exchange Base Plan ID: 33709PA0870001-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$1,000	No Coverage
Deductible-Aggregate (Family)	$2,000	
Out of Pocket Maximum (Individual)	$7,000	
Out of Pocket Maximum- Aggregate (Family)	$14,000	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $20 copay	No Coverage
Specialist Office & Virtual Visits	$45 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $45 copay	
Telemedicine Service	$15 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	20% after deductible	No Coverage
Hospital Outpatient	20% after deductible	
Inpatient Hospital Maternity	20% after deductible	
Medical Care and Surgical Expenses	20% after deductible	
Emergency Services		
Urgent Care Center Visits	$45 copay	$45 copay
Emergency Room Services *(Copay Waived if Admitted)*	$500 copay after deductible	$500 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	$45 copay	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	$45 copay	
Chiropractor Services	$45 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$50 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	20% after deductible	
Lab/Pathology	$25 copay	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min/$2,000 Max)

Counties Plan Available In: Blair, Cambria, and Somerset

Major Events Blue PPO, a Community Blue Plan 7900 **CATASTROPHIC**

On-Exchange Base Plan ID: 33709PA0380004-01 **Off-Exchange Base Plan ID: 33709PA0380004-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$7,900	$15,800
Deductible-Aggregate (Family)	$15,800	$31,600
Out of Pocket Maximum (Individual)	$7,900	$15,800
Out of Pocket Maximum (Family)	$15,800	$31,600
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	0% first 3 visits then 0% After Deductible	0% After Deductible
Specialist Office & Virtual Visits	0% After Deductible	0% After Deductible
Outpatient Mental Health Visits	0% After Deductible	0% After Deductible
Telemedicine Service	0% After Deductible	No Coverage
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	0% After Deductible	0% After Deductible
Hospital Outpatient	0% After Deductible	0% After Deductible
Inpatient Hospital Maternity	0% After Deductible	0% After Deductible
Medical Care and Surgical Expenses	0% After Deductible	0% After Deductible
Emergency Services		
Urgent Care Center Visits	0% After Deductible	0% After Deductible
Emergency Room Services	0% After Deductible	0% After Deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	0% After Deductible	0% After Deductible
Speech Therapy (Rehabilitative and Habilitative)	0% After Deductible	0% After Deductible
Chiropractor Services	0% After Deductible	0% After Deductible
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	0% After Deductible	0% After Deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	0% After Deductible	0% After Deductible
Lab/Pathology	0% After Deductible	0% After Deductible

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	0% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible
Prescription Drug Coverage Mail (90 days supply)	0% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible

Counties Plan Available In: Blair, Cambria, and Somerset

my Direct Blue Conemaugh EPO Bronze 7900 **BRONZE**

On-Exchange Base Plan ID: 33709PA0860008-01 **Off-Exchange Base Plan ID: 33709PA0860008-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$7,900	No Coverage
Deductible-Aggregate (Family)	$15,800	
Out of Pocket Maximum (Individual)	$7,900	
Out of Pocket Maximum- Aggregate (Family)	$15,800	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	0% after deductible	No Coverage
Specialist Office & Virtual Visits	0% after deductible	
Outpatient Mental Health Visits	0% first 2 visits then 0% after deductible	
Telemedicine Service	0% after deductible	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	0% after deductible	No Coverage
Hospital Outpatient	0% after deductible	
Inpatient Hospital Maternity	0% after deductible	
Medical Care and Surgical Expenses	0% after deductible	
Emergency Services		
Urgent Care Center Visits	0% after deductible	0% after deductible
Emergency Room Services	0% after deductible	0% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	0% after deductible	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	0% after deductible	
Chiropractor Services	0% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	0% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	0% after deductible	
Lab/Pathology	0% after deductible	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	0% after deductible	0% after deductible	0% after deductible	0% after deductible
Prescription Drug Coverage Mail (90 days supply)	0% after deductible	0% after deductible	0% after deductible	0% after deductible

Counties Plan Available In: Blair, Cambria, and Somerset

my Direct Blue Conemaugh EPO Bronze 4000 **BRONZE**

On-Exchange Base Plan ID: 33709PA0860007-01 **Off -Exchange Base Plan ID: 33709PA0860007-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$4,000	No Coverage
Deductible-Aggregate (Family)	$8,000	
Out of Pocket Maximum (Individual)	$7,900	
Out of Pocket Maximum- Aggregate (Family)	$15,800	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$60 copay	No Coverage
Specialist Office & Virtual Visits	30% after deductible	
Outpatient Mental Health Visits	0% first 2 visits then 30% after deductible	
Telemedicine Service	$25 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	30% after deductible	30% after deductible
Emergency Room Services	30% after deductible	30% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	30% after deductible	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	30% after deductible	
Chiropractor Services	30% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	30% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	30% after deductible	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Prescription Drug Coverage Mail (90 days supply)	30% after deductible	30% after deductible	30% after deductible	30% after deductible

Counties Plan Available In: Blair, Cambria, and Somerset

my Direct Blue Conemaugh EPO Silver 4450 HSA — SILVER

On-Exchange Base Plan ID: 33709PA0880001-01 Off-Exchange Base Plan ID: 33709PA0880001-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$4,450	No Coverage
Deductible-Embedded (Family)	$8,900	
Out of Pocket Maximum (Individual)	$6,650	
Out of Pocket Maximum (Family)	$13,300	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	10% after deductible	No Coverage
Specialist Office & Virtual Visits	10% after deductible	
Outpatient Mental Health Visits	10% after deductible	
Telemedicine Service	10% after deductible	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	10% after deductible	No Coverage
Hospital Outpatient	10% after deductible	
Inpatient Hospital Maternity	10% after deductible	
Medical Care and Surgical Expenses	10% after deductible	
Emergency Services		
Urgent Care Center Visits	10% after deductible	10% after deductible
Emergency Room Services	10% after deductible	10% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	10% after deductible	No Coverage
Speech Therapy (Rehabilitative and Habilitative)	10% after deductible	
Chiropractor Services	10% after deductible	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	10% after deductible	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	10% after deductible	
Lab/Pathology	10% after deductible	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Prescription Drug Coverage Mail (90 days supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible

Counties Plan Available In: Blair, Cambria, and Somerset

my Direct Blue Conemaugh EPO Silver 2400 - 2 Free PCP Visits — SILVER

On-Exchange Base Plan ID: 33709PA0860002-01 **Off-Exchange Base Plan ID: 33709PA0860002-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$2,400	No Coverage
Deductible-Aggregate (Family)	$4,800	
Out of Pocket Maximum (Individual)	$7,800	
Out of Pocket Maximum (Family)	$15,600	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $40 copay	No Coverage
Specialist Office & Virtual Visits	$90 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $90 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	$90 copay	$90 copay
Emergency Room Services *(Copay Waived if Admitted)*	$750 copay after deductible	$750 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$90 copay	No Coverage
Speech Therapy (Rehabilitative and Habilitative)	$90 copay	
Chiropractor Services	$90 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$90 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	$55 copay	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min / $1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min / $2,000 Max)

Counties Plan Available In: Blair, Cambria, and Somerset

my Direct Blue Conemaugh EPO Silver 0 — SILVER

On-Exchange Base Plan ID: 33709PA0860009-01 Off-Exchange Base Plan ID: 33709PA0860009-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$0	No Coverage
Deductible-Aggregate (Family)	$0	
Out of Pocket Maximum (Individual)	$7,800	
Out of Pocket Maximum (Family)	$15,600	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$40 copay	No Coverage
Specialist Office & Virtual Visits	$90 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $90 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	$3,900 copay per day (Two Day Max)	No Coverage
Hospital Outpatient	40%	
Inpatient Hospital Maternity	$3,900 copay per day (Two Day Max)	
Medical Care and Surgical Expenses	40%	
Emergency Services		
Urgent Care Center Visits	$90 copay	$90 copay
Emergency Room Services *(Copay Waived if Admitted)*	$1,400 copay	$1,400 copay
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$90 copay	No Coverage
Speech Therapy (Rehabilitative and Habilitative)	$90 copay	
Chiropractor Services	$90 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$90 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	40%	
Lab/Pathology	$45 copay	

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35%	50% ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35%	50% ($500 Min/$2,000 Max)

Counties Plan Available In: Blair, Cambria, and Somerset

my Direct Blue Conemaugh EPO Gold 1000 - 2 Free PCP Visits — GOLD

On-Exchange Base Plan ID: 33709PA0860001-01 **Off-Exchange Base Plan ID: 33709PA0860001-00**

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out-of-Pocket Costs		
Deductible (Individual)	$1,000	No Coverage
Deductible-Aggregate (Family)	$2,000	
Out of Pocket Maximum (Individual)	$7,000	
Out of Pocket Maximum- Aggregate (Family)	$14,000	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $20 copay	No Coverage
Specialist Office & Virtual Visits	$45 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $45 copay	
Telemedicine Service	$15 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	20% after deductible	No Coverage
Hospital Outpatient	20% after deductible	
Inpatient Hospital Maternity	20% after deductible	
Medical Care and Surgical Expenses	20% after deductible	
Emergency Services		
Urgent Care Center Visits	$45 copay	$45 copay
Emergency Room Services *(Copay Waived if Admitted)*	$500 copay after deductible	$500 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Therapy (Rehabilitative and Habilitative)	$45 copay	No Coverage
Speech & Occupational Therapy (Rehabilitative and Habilitative)	$45 copay	
Chiropractor Services	$45 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$50 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	20% after deductible	
Lab/Pathology	$25 copay	

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min/$2,000 Max)

The following Highmark plan options are not available on the Marketplace and may be purchased directly through Highmark without financial help in select Pennsylvania counties:

- **Major Events Blue PPO, a Community Blue plan 7900**
- **Shared Cost Blue PPO Bronze 7500**
- **my Direct Blue EPO Silver 3500 – 2 Free PCP Visits**
- **my Direct Blue Erie HMO Silver 3500 – 2 Free PCP Visits**
- **my Direct Blue Conemaugh EPO Silver 3500 – 2 Free PCP Visits**

Counties Plan Available In: Allegheny, Washington, Westmoreland

Major Events Blue PPO, a Community Blue Plan 7900 — CATASTROPHIC

Off-Exchange Base Plan ID: 33709PA0380003-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$7,900	$15,800
Deductible-Aggregate (Family)	$15,800	$31,600
Out of Pocket Maximum (Individual)	$7,900	$15,800
Out of Pocket Maximum (Family)	$15,800	$31,600
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	0% first 3 visits then 0% After Deductible	0% After Deductible
Specialist Office & Virtual Visits	0% After Deductible	0% After Deductible
Outpatient Mental Health Visits	0% After Deductible	0% After Deductible
Telemedicine Service	0% After Deductible	No Coverage
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	0% After Deductible	0% After Deductible
Hospital Outpatient	0% After Deductible	0% After Deductible
Inpatient Hospital Maternity	0% After Deductible	0% After Deductible
Medical Care and Surgical Expenses	0% After Deductible	0% After Deductible
Emergency Services		
Urgent Care Center Visits	0% After Deductible	0% After Deductible
Emergency Room Services	0% After Deductible	0% After Deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	0% After Deductible	0% After Deductible
Speech Therapy (Rehabilitative and Habilitative)	0% After Deductible	0% After Deductible
Chiropractor Services	0% After Deductible	0% After Deductible
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	0% After Deductible	0% After Deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	0% After Deductible	0% After Deductible
Lab/Pathology	0% After Deductible	0% After Deductible

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	0% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible
Prescription Drug Coverage Mail (90 days supply)	0% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible

Counties Plan Available In: Allegheny, Washington, Westmoreland

Shared Cost Blue PPO Bronze 7500 **BRONZE**

Off-Exchange Base Plan ID: 70194PA0260001-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Out-of-Network Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$7,500	$22,500
Deductible-Aggregate (Family)	$15,000	$45,000
Out of Pocket Maximum (Individual)	$7,900	$23,700
Out of Pocket Maximum (Family)	$15,800	$47,400
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$70 copay	50% after deductible
Specialist Office & Virtual Visits	$100 copay	50% after deductible
Outpatient Mental Health Visits	$0 first 2 visits then $100 copay	50% after deductible
Telemedicine Service	$20 copay	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	50% after deductible
Hospital Outpatient	30% after deductible	50% after deductible
Inpatient Hospital Maternity	30% after deductible	50% after deductible
Medical Care and Surgical Expenses	30% after deductible	50% after deductible
Emergency Services		
Urgent Care Center Visits	$100 copay	50% after deductible
Emergency Room Services	30% after deductible	30% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Speech Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Chiropractor Services	$100 copay	50% after deductible
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$100 copay	50% after deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	50% after deductible
Lab/Pathology	$80 copay	50% after deductible

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min / $1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min / $2,000 Max)

Counties Plan Available In: Allegheny, Washington, Westmoreland

my Direct Blue HMO Silver 3500 - 2 Free PCP Visits — SILVER

Off-Exchange Base Plan ID: 38949PA0080010-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$3,500	No Coverage
Deductible-Aggregate (Family)	$7,000	
Out of Pocket Maximum (Individual)	$7,700	
Out of Pocket Maximum (Family)	$15,400	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $50 copay	No Coverage
Specialist Office & Virtual Visits	$100 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $100 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	$100 copay	$100 copay
Emergency Room Services *(Copay Waived if Admitted)*	$700 copay after deductible	$700 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$100 copay	No Coverage
Speech Therapy (Rehabilitative and Habilitative)	$100 copay	
Chiropractor Services	$100 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$110 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	$60 copay	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min/$2,000 Max)

Counties Plan Available In: Erie

Major Events Blue PPO, a Community Blue Plan 7900 — CATASTROPHIC

Off-Exchange Base Plan ID: 33709PA0380003-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$7,900	$15,800
Deductible-Aggregate (Family)	$15,800	$31,600
Out of Pocket Maximum (Individual)	$7,900	$15,800
Out of Pocket Maximum (Family)	$15,800	$31,600
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	0% first 3 visits then 0% After Deductible	0% After Deductible
Specialist Office & Virtual Visits	0% After Deductible	0% After Deductible
Outpatient Mental Health Visits	0% After Deductible	0% After Deductible
Telemedicine Service	0% After Deductible	No Coverage
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	0% After Deductible	0% After Deductible
Hospital Outpatient	0% After Deductible	0% After Deductible
Inpatient Hospital Maternity	0% After Deductible	0% After Deductible
Medical Care and Surgical Expenses	0% After Deductible	0% After Deductible
Emergency Services		
Urgent Care Center Visits	0% After Deductible	0% After Deductible
Emergency Room Services	0% After Deductible	0% After Deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	0% After Deductible	0% After Deductible
Speech Therapy (Rehabilitative and Habilitative)	0% After Deductible	0% After Deductible
Chiropractor Services	0% After Deductible	0% After Deductible
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	0% After Deductible	0% After Deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	0% After Deductible	0% After Deductible
Lab/Pathology	0% After Deductible	0% After Deductible

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	0% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible
Prescription Drug Coverage Mail (90 days supply)	0% After Deductible	0% After Deductible	0% After Deductible	0% After Deductible

Counties Plan Available In: Erie

Shared Cost Blue PPO Bronze 7500 — BRONZE

Off-Exchange Base Plan ID: 70194PA0260001-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Out-of-Network Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$7,500	$22,500
Deductible-Aggregate (Family)	$15,000	$45,000
Out of Pocket Maximum (Individual)	$7,900	$23,700
Out of Pocket Maximum (Family)	$15,800	$47,400
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$70 copay	50% after deductible
Specialist Office & Virtual Visits	$100 copay	50% after deductible
Outpatient Mental Health Visits	$0 first 2 visits then $100 copay	50% after deductible
Telemedicine Service	$20 copay	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	50% after deductible
Hospital Outpatient	30% after deductible	50% after deductible
Inpatient Hospital Maternity	30% after deductible	50% after deductible
Medical Care and Surgical Expenses	30% after deductible	50% after deductible
Emergency Services		
Urgent Care Center Visits	$100 copay	50% after deductible
Emergency Room Services	30% after deductible	30% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Speech Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Chiropractor Services	$100 copay	50% after deductible
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$100 copay	50% after deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	50% after deductible
Lab/Pathology	$80 copay	50% after deductible

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min / $1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min / $2,000 Max)

Counties Plan Available In: Erie

my Direct Blue ERIE HMO Silver 3500 - 2 Free PCP Visits — SILVER

Off-Exchange Base Plan ID: 38949PA0100005-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$3,500	No Coverage
Deductible-Aggregate (Family)	$7,000	
Out of Pocket Maximum (Individual)	$7,700	
Out of Pocket Maximum (Family)	$15,400	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $50 copay	No Coverage
Specialist Office & Virtual Visits	$100 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $100 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	$100 copay	$100 copay
Emergency Room Services *(Copay Waived if Admitted)*	$700 copay after deductible	$700 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$100 copay	No Coverage
Speech Therapy (Rehabilitative and Habilitative)	$100 copay	
Chiropractor Services	$100 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$110 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	$60 copay	

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min/$2,000 Max)

Counties Plan Available In: Armstrong, Beaver, Butler, Clarion, Crawford, Forest, Warren

Shared Cost Blue PPO Bronze 7500 — BRONZE

Off-Exchange Base Plan ID: 70194PA0260001-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Out-of-Network Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$7,500	$22,500
Deductible-Aggregate (Family)	$15,000	$45,000
Out of Pocket Maximum (Individual)	$7,900	$23,700
Out of Pocket Maximum (Family)	$15,800	$47,400
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$70 copay	50% after deductible
Specialist Office & Virtual Visits	$100 copay	50% after deductible
Outpatient Mental Health Visits	$0 first 2 visits then $100 copay	50% after deductible
Telemedicine Service	$20 copay	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	50% after deductible
Hospital Outpatient	30% after deductible	50% after deductible
Inpatient Hospital Maternity	30% after deductible	50% after deductible
Medical Care and Surgical Expenses	30% after deductible	50% after deductible
Emergency Services		
Urgent Care Center Visits	$100 copay	50% after deductible
Emergency Room Services	30% after deductible	30% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Speech Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Chiropractor Services	$100 copay	50% after deductible
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$100 copay	50% after deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	50% after deductible
Lab/Pathology	$80 copay	50% after deductible

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min / $1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min / $2,000 Max)

Counties Plan Available In: Armstrong, Beaver, Butler, Clarion, Crawford, Forest, Warren

my Direct Blue EPO Silver 3500 - 2 Free PCP Visits — SILVER

Off-Exchange Base Plan ID: 33709PA0870010-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$3,500	No Coverage
Deductible-Aggregate (Family)	$7,000	
Out of Pocket Maximum (Individual)	$7,700	
Out of Pocket Maximum (Family)	$15,400	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $50 copay	No Coverage
Specialist Office & Virtual Visits	$100 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $100 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	$100 copay	$100 copay
Emergency Room Services *(Copay Waived if Admitted)*	$700 copay after deductible	$700 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$100 copay	No Coverage
Speech Therapy (Rehabilitative and Habilitative)	$100 copay	
Chiropractor Services	$100 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$110 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	$60 copay	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min/$2,000 Max)

Counties Plan Available In: Blair, Cambria, and Somerset

Shared Cost Blue PPO Bronze 7500 — BRONZE

Off-Exchange Base Plan ID: 70194PA0260001-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Out-of-Network Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$7,500	$22,500
Deductible-Aggregate (Family)	$15,000	$45,000
Out of Pocket Maximum (Individual)	$7,900	$23,700
Out of Pocket Maximum (Family)	$15,800	$47,400
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$70 copay	50% after deductible
Specialist Office & Virtual Visits	$100 copay	50% after deductible
Outpatient Mental Health Visits	$0 first 2 visits then $100 copay	50% after deductible
Telemedicine Service	$20 copay	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	50% after deductible
Hospital Outpatient	30% after deductible	50% after deductible
Inpatient Hospital Maternity	30% after deductible	50% after deductible
Medical Care and Surgical Expenses	30% after deductible	50% after deductible
Emergency Services		
Urgent Care Center Visits	$100 copay	50% after deductible
Emergency Room Services	30% after deductible	30% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Speech Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Chiropractor Services	$100 copay	50% after deductible
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$100 copay	50% after deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	50% after deductible
Lab/Pathology	$80 copay	50% after deductible
Prescription Drugs		
Formulary- Essential (Drug List)		

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min / $1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min / $2,000 Max)

Counties Plan Available In: Blair, Cambria, and Somerset

my Direct Blue Conemaugh EPO Silver 3500 - 2 Free PCP Visits — SILVER

Off-Exchange Base Plan ID: 33709PA0860010-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$3,500	No Coverage
Deductible-Aggregate (Family)	$7,000	
Out of Pocket Maximum (Individual)	$7,700	
Out of Pocket Maximum (Family)	$15,400	
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$0 first 2 visits then $50 copay	No Coverage
Specialist Office & Virtual Visits	$100 copay	
Outpatient Mental Health Visits	$0 first 2 visits then $100 copay	
Telemedicine Service	$20 copay	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	No Coverage
Hospital Outpatient	30% after deductible	
Inpatient Hospital Maternity	30% after deductible	
Medical Care and Surgical Expenses	30% after deductible	
Emergency Services		
Urgent Care Center Visits	$100 copay	$100 copay
Emergency Room Services *(Copay Waived if Admitted)*	$700 copay after deductible	$700 copay after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$100 copay	No Coverage
Speech Therapy (Rehabilitative and Habilitative)	$100 copay	
Chiropractor Services	$100 copay	
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$110 copay	No Coverage
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	
Lab/Pathology	$60 copay	

Prescription Drugs

Formulary- Essential (Drug List)

Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min/$1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min/$2,000 Max)

Counties Plan Available In: Bedford, Cameron, Clearfield, Elk, Fayette, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango

Shared Cost Blue PPO Bronze 7500 — BRONZE

Off-Exchange Base Plan ID: 70194PA0260001-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Out-of-Network Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$7,500	$22,500
Deductible-Aggregate (Family)	$15,000	$45,000
Out of Pocket Maximum (Individual)	$7,900	$23,700
Out of Pocket Maximum (Family)	$15,800	$47,400
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$70 copay	50% after deductible
Specialist Office & Virtual Visits	$100 copay	50% after deductible
Outpatient Mental Health Visits	$0 first 2 visits then $100 copay	50% after deductible
Telemedicine Service	$20 copay	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	50% after deductible
Hospital Outpatient	30% after deductible	50% after deductible
Inpatient Hospital Maternity	30% after deductible	50% after deductible
Medical Care and Surgical Expenses	30% after deductible	50% after deductible
Emergency Services		
Urgent Care Center Visits	$100 copay	50% after deductible
Emergency Room Services	30% after deductible	30% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Speech Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Chiropractor Services	$100 copay	50% after deductible
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$100 copay	50% after deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	50% after deductible
Lab/Pathology	$80 copay	50% after deductible

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min / $1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min / $2,000 Max)

Counties Plan Available In: Centre*

*You must reside in one of the following ZIP codes in Centre County to enroll in one of these plans — 16677, 16686, 16829, 16845, 16859, 16866, 16874

Shared Cost Blue PPO Bronze 7500 — BRONZE

Off-Exchange Base Plan ID: 70194PA0260001-00

The chart below shows in-network and out-of-network costs for all categories as a member.

Benefit	In-Network	Out-of-Network
Preventive Testing & Screenings		
Covered in full* Preventive care includes services such as childhood immunizations, annual wellness exams, mammography screenings, and flu shots. Office visit copay may apply for some screenings.		No Out-of-Network Coverage
Deductible and Out of Pocket Costs		
Deductible (Individual)	$7,500	$22,500
Deductible-Aggregate (Family)	$15,000	$45,000
Out of Pocket Maximum (Individual)	$7,900	$23,700
Out of Pocket Maximum (Family)	$15,800	$47,400
Office/Clinic/Telemedicine Visits		
Primary Care or Retail Clinic Office Visits	$70 copay	50% after deductible
Specialist Office & Virtual Visits	$100 copay	50% after deductible
Outpatient Mental Health Visits	$0 first 2 visits then $100 copay	50% after deductible
Telemedicine Service	$20 copay	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	30% after deductible	50% after deductible
Hospital Outpatient	30% after deductible	50% after deductible
Inpatient Hospital Maternity	30% after deductible	50% after deductible
Medical Care and Surgical Expenses	30% after deductible	50% after deductible
Emergency Services		
Urgent Care Center Visits	$100 copay	50% after deductible
Emergency Room Services	30% after deductible	30% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical & Occupational Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Speech Therapy (Rehabilitative and Habilitative)	$100 copay	50% after deductible
Chiropractor Services	$100 copay	50% after deductible
Diagnostic Services		
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	$100 copay	50% after deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	30% after deductible	50% after deductible
Lab/Pathology	$80 copay	50% after deductible

Prescription Drugs				
Formulary- Essential (Drug List)				
Tiers	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
Prescription Drug Coverage Retail (31 days supply)	$5 copay	$30 copay	35% no deductible	50% no deductible ($250 Min / $1,000 Max)
Prescription Drug Coverage Mail (90 days supply)	$10 copay	$60 copay	35% no deductible	50% no deductible ($500 Min / $2,000 Max)

BE KNOWLEDGEABLE with Monthly Premiums by County

Understand How Your Monthly Premium Is Calculated

At Highmark, we want you to trust in the value of your health care coverage. To help you understand how we calculate the price you pay, we have included a guide to rates on **pages 55–68**. The premium rate listed is the most a person* will pay for their premium each month.

Find Your Premium By:

- The Highmark plan you wish to purchase
- Your age — and the age of each dependent on your plan
- Your tobacco use — and the tobacco use of each dependent on your plan

If You Have More Than Three Children Under Age 21:

Only include rates for you, your spouse/domestic partner, children between ages 21 and 26, and/or the three oldest children under age 21. Your policy will also cover your remaining children. Please include them as eligible dependents when you enroll.

**If you are also enrolling family members, you will need to get the base rate for each member of your family. Add these base rates together to get the rate that covers the family members on your plan.*

PREMIUM RATES FOR YOUR COUNTY

(Use the Plan ID to find your plan on the Marketplace.)

Allegheny, Washington, and Westmoreland

	Bronze		Bronze		Silver		Silver	
	my Direct Blue HMO Bronze 7900		my Direct Blue HMO Bronze 4000		my Direct Blue HMO Silver 4450 HSA		my Direct Blue HMO Silver 2400 - 2 Free PCP Visits	
Plan ID	38949PA0080008		38949PA0080007		38949PA0090001		38949PA0080002	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$ 201.59	$ 201.59	$ 209.52	$ 209.52	$ 287.98	$ 287.98	$ 302.14	$ 302.14
15	$ 219.51	$ 219.51	$ 228.14	$ 228.14	$ 313.57	$ 313.57	$ 328.99	$ 328.99
16	$ 226.36	$ 226.36	$ 235.26	$ 235.26	$ 323.36	$ 323.36	$ 339.26	$ 339.26
17	$ 233.22	$ 233.22	$ 242.38	$ 242.38	$ 333.15	$ 333.15	$ 349.53	$ 349.53
18	$ 240.59	$ 240.59	$ 250.05	$ 250.05	$ 343.69	$ 343.69	$ 360.59	$ 360.59
19	$ 247.97	$ 247.97	$ 257.72	$ 257.72	$ 354.23	$ 354.23	$ 371.65	$ 371.65
20	$ 255.61	$ 255.61	$ 265.66	$ 265.66	$ 365.15	$ 365.15	$ 383.10	$ 383.10
21	$ 263.52	$ 270.11	$ 273.88	$ 280.73	$ 376.44	$ 385.85	$ 394.95	$ 404.83
22	$ 263.52	$ 270.11	$ 273.88	$ 280.73	$ 376.44	$ 385.85	$ 394.95	$ 404.82
23	$ 263.52	$ 270.11	$ 273.88	$ 280.73	$ 376.44	$ 385.85	$ 394.95	$ 404.82
24	$ 263.52	$ 270.11	$ 273.88	$ 280.73	$ 376.44	$ 385.85	$ 394.95	$ 404.82
25	$ 264.57	$ 271.18	$ 274.98	$ 281.85	$ 377.95	$ 387.40	$ 396.53	$ 406.44
26	$ 269.84	$ 276.59	$ 280.45	$ 287.46	$ 385.47	$ 395.11	$ 404.43	$ 414.54
27	$ 276.17	$ 283.07	$ 287.03	$ 294.21	$ 394.51	$ 404.37	$ 413.91	$ 424.26
28	$ 286.45	$ 293.61	$ 297.71	$ 305.15	$ 409.19	$ 419.42	$ 429.31	$ 440.04
29	$ 294.88	$ 302.25	$ 306.47	$ 314.13	$ 421.24	$ 431.77	$ 441.95	$ 453.00
30	$ 299.10	$ 306.58	$ 310.85	$ 318.62	$ 427.26	$ 437.94	$ 448.27	$ 459.48
31	$ 305.42	$ 313.06	$ 317.43	$ 325.37	$ 436.29	$ 447.20	$ 457.75	$ 469.19
32	$ 311.74	$ 319.53	$ 324.00	$ 332.10	$ 445.33	$ 456.46	$ 467.23	$ 478.91
33	$ 315.70	$ 323.59	$ 328.11	$ 336.31	$ 450.98	$ 462.25	$ 473.15	$ 484.98
34	$ 319.91	$ 327.91	$ 332.49	$ 340.80	$ 457.00	$ 468.43	$ 479.47	$ 491.46
35	$ 322.02	$ 330.07	$ 334.68	$ 343.05	$ 460.01	$ 471.51	$ 482.63	$ 494.70
36	$ 324.13	$ 332.23	$ 336.87	$ 345.29	$ 463.02	$ 474.60	$ 485.79	$ 497.93
37	$ 326.24	$ 334.40	$ 339.06	$ 347.54	$ 466.03	$ 477.68	$ 488.95	$ 501.17
38	$ 328.35	$ 336.56	$ 341.25	$ 349.78	$ 469.04	$ 480.77	$ 492.11	$ 504.41
39	$ 332.56	$ 340.87	$ 345.64	$ 354.28	$ 475.07	$ 486.95	$ 498.43	$ 510.89
40	$ 336.78	$ 370.46	$ 350.02	$ 385.02	$ 481.09	$ 529.20	$ 504.75	$ 555.23
41	$ 343.10	$ 379.13	$ 356.59	$ 394.03	$ 490.12	$ 541.58	$ 514.22	$ 568.21
42	$ 349.16	$ 388.27	$ 362.89	$ 403.53	$ 498.78	$ 554.64	$ 523.31	$ 581.92
43	$ 357.60	$ 400.87	$ 371.66	$ 416.63	$ 510.83	$ 572.64	$ 535.95	$ 600.80
44	$ 368.14	$ 416.73	$ 382.61	$ 433.11	$ 525.89	$ 595.31	$ 551.75	$ 624.58
45	$ 380.52	$ 435.70	$ 395.48	$ 452.82	$ 543.58	$ 622.40	$ 570.31	$ 653.00
46	$ 395.28	$ 458.52	$ 410.82	$ 476.55	$ 564.66	$ 655.01	$ 592.43	$ 687.22
47	$ 411.88	$ 484.78	$ 428.07	$ 503.84	$ 588.38	$ 692.52	$ 617.31	$ 726.57
48	$ 430.86	$ 515.31	$ 447.79	$ 535.56	$ 615.48	$ 736.11	$ 645.74	$ 772.31
49	$ 449.57	$ 547.13	$ 467.24	$ 568.63	$ 642.21	$ 781.57	$ 673.78	$ 819.99
50	$ 470.65	$ 576.55	$ 489.15	$ 599.21	$ 672.32	$ 823.59	$ 705.38	$ 864.09
51	$ 491.46	$ 602.04	$ 510.79	$ 625.72	$ 702.06	$ 860.02	$ 736.58	$ 902.31
52	$ 514.39	$ 630.13	$ 534.61	$ 654.90	$ 734.81	$ 900.14	$ 770.94	$ 944.40
53	$ 537.58	$ 658.54	$ 558.72	$ 684.43	$ 767.94	$ 940.73	$ 805.70	$ 986.98
54	$ 562.62	$ 689.21	$ 584.73	$ 716.29	$ 803.70	$ 984.53	$ 843.22	$ 1,032.94
55	$ 587.65	$ 719.87	$ 610.75	$ 748.17	$ 839.46	$ 1,028.34	$ 880.74	$ 1,078.91
56	$ 614.79	$ 753.12	$ 638.96	$ 782.73	$ 878.23	$ 1,075.83	$ 921.42	$ 1,128.74
57	$ 642.20	$ 786.70	$ 667.45	$ 817.63	$ 917.38	$ 1,123.79	$ 962.49	$ 1,179.05
58	$ 671.45	$ 822.53	$ 697.85	$ 854.87	$ 959.17	$ 1,174.98	$ 1,006.33	$ 1,232.75
59	$ 685.94	$ 840.28	$ 712.91	$ 873.31	$ 979.87	$ 1,200.34	$ 1,028.05	$ 1,259.36
60	$ 715.19	$ 876.11	$ 743.31	$ 910.55	$ 1,021.66	$ 1,251.53	$ 1,071.89	$ 1,313.07
61	$ 740.49	$ 907.10	$ 769.60	$ 942.76	$ 1,057.80	$ 1,295.81	$ 1,109.81	$ 1,359.52
62	$ 757.09	$ 927.44	$ 786.86	$ 963.90	$ 1,081.51	$ 1,324.85	$ 1,134.69	$ 1,390.00
63	$ 777.91	$ 952.94	$ 808.49	$ 990.40	$ 1,111.25	$ 1,361.28	$ 1,165.89	$ 1,428.22
64+	$ 790.56	$ 968.44	$ 821.64	$ 1,006.51	$ 1,129.32	$ 1,383.42	$ 1,184.85	$ 1,451.44

PREMIUM RATES FOR YOUR COUNTY

(Use the Plan ID to find your plan on the Marketplace.)

Allegheny, Washington, and Westmoreland

	Silver		Gold	
	my Direct Blue HMO Silver 0		my Direct Blue HMO Gold 1000 - 2 Free PCP Visits	
Plan ID	38949PA0080009		38949PA0080001	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$ 321.30	$ 321.30	$ 305.58	$ 305.58
15	$ 349.86	$ 349.86	$ 332.74	$ 332.74
16	$ 360.78	$ 360.78	$ 343.13	$ 343.13
17	$ 371.70	$ 371.70	$ 353.51	$ 353.51
18	$ 383.46	$ 383.46	$ 364.70	$ 364.70
19	$ 395.22	$ 395.22	$ 375.88	$ 375.88
20	$ 407.40	$ 407.40	$ 387.47	$ 387.47
21	$ 420.00	$ 430.50	$ 399.45	$ 409.43
22	$ 420.00	$ 430.50	$ 399.45	$ 409.44
23	$ 420.00	$ 430.50	$ 399.45	$ 409.44
24	$ 420.00	$ 430.50	$ 399.45	$ 409.44
25	$ 421.68	$ 432.22	$ 401.05	$ 411.08
26	$ 430.08	$ 440.83	$ 409.04	$ 419.27
27	$ 440.16	$ 451.16	$ 418.62	$ 429.09
28	$ 456.54	$ 467.95	$ 434.20	$ 445.06
29	$ 469.98	$ 481.73	$ 446.98	$ 458.15
30	$ 476.70	$ 488.62	$ 453.38	$ 464.71
31	$ 486.78	$ 498.95	$ 462.96	$ 474.53
32	$ 496.86	$ 509.28	$ 472.55	$ 484.36
33	$ 503.16	$ 515.74	$ 478.54	$ 490.50
34	$ 509.88	$ 522.63	$ 484.93	$ 497.05
35	$ 513.24	$ 526.07	$ 488.13	$ 500.33
36	$ 516.60	$ 529.52	$ 491.32	$ 503.60
37	$ 519.96	$ 532.96	$ 494.52	$ 506.88
38	$ 523.32	$ 536.40	$ 497.71	$ 510.15
39	$ 530.04	$ 543.29	$ 504.11	$ 516.71
40	$ 536.76	$ 590.44	$ 510.50	$ 561.55
41	$ 546.84	$ 604.26	$ 520.08	$ 574.69
42	$ 556.50	$ 618.83	$ 529.27	$ 588.55
43	$ 569.94	$ 638.90	$ 542.05	$ 607.64
44	$ 586.74	$ 664.19	$ 558.03	$ 631.69
45	$ 606.48	$ 694.42	$ 576.81	$ 660.45
46	$ 630.00	$ 730.80	$ 599.18	$ 695.05
47	$ 656.46	$ 772.65	$ 624.34	$ 734.85
48	$ 686.70	$ 821.29	$ 653.10	$ 781.11
49	$ 716.52	$ 872.00	$ 681.46	$ 829.34
50	$ 750.12	$ 918.90	$ 713.42	$ 873.94
51	$ 783.30	$ 959.54	$ 744.97	$ 912.59
52	$ 819.84	$ 1,004.30	$ 779.73	$ 955.17
53	$ 856.80	$ 1,049.58	$ 814.88	$ 998.23
54	$ 896.70	$ 1,098.46	$ 852.83	$ 1,044.72
55	$ 936.60	$ 1,147.34	$ 890.77	$ 1,091.19
56	$ 979.86	$ 1,200.33	$ 931.92	$ 1,141.60
57	$ 1,023.54	$ 1,253.84	$ 973.46	$ 1,192.49
58	$ 1,070.16	$ 1,310.95	$ 1,017.80	$ 1,246.81
59	$ 1,093.26	$ 1,339.24	$ 1,039.77	$ 1,273.72
60	$ 1,139.88	$ 1,396.35	$ 1,084.11	$ 1,328.03
61	$ 1,180.20	$ 1,445.75	$ 1,122.45	$ 1,375.00
62	$ 1,206.66	$ 1,478.16	$ 1,147.62	$ 1,405.83
63	$ 1,239.84	$ 1,518.80	$ 1,179.18	$ 1,444.50
64+	$ 1,260.00	$ 1,543.50	$ 1,198.35	$ 1,467.98

PREMIUM RATES FOR YOUR COUNTY

(Use the Plan ID to find your plan on the Marketplace.)

Erie

	Bronze		Bronze		Silver		Silver	
	my Direct Blue Erie HMO Bronze 7900		my Direct Blue Erie HMO Bronze 4000		my Direct Blue Erie HMO Silver 4450 HSA		my Direct Blue Erie HMO Silver 2400 - 2 Free PCP Visits	
Plan ID	38949PA0100002		38949PA0100001		38949PA0110001		38949PA0100003	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$ 143.98	$ 143.98	$ 149.64	$ 149.64	$ 205.67	$ 205.67	$ 215.79	$ 215.79
15	$ 156.78	$ 156.78	$ 162.94	$ 162.94	$ 223.95	$ 223.95	$ 234.97	$ 234.97
16	$ 161.67	$ 161.67	$ 168.03	$ 168.03	$ 230.94	$ 230.94	$ 242.31	$ 242.31
17	$ 166.57	$ 166.57	$ 173.11	$ 173.11	$ 237.93	$ 237.93	$ 249.64	$ 249.64
18	$ 171.84	$ 171.84	$ 178.59	$ 178.59	$ 245.46	$ 245.46	$ 257.54	$ 257.54
19	$ 177.11	$ 177.11	$ 184.07	$ 184.07	$ 252.99	$ 252.99	$ 265.44	$ 265.44
20	$ 182.56	$ 182.56	$ 189.74	$ 189.74	$ 260.78	$ 260.78	$ 273.62	$ 273.62
21	$ 188.21	$ 192.91	$ 195.61	$ 200.50	$ 268.85	$ 275.58	$ 282.08	$ 289.13
22	$ 188.21	$ 192.92	$ 195.61	$ 200.50	$ 268.85	$ 275.57	$ 282.08	$ 289.13
23	$ 188.21	$ 192.92	$ 195.61	$ 200.50	$ 268.85	$ 275.57	$ 282.08	$ 289.13
24	$ 188.21	$ 192.92	$ 195.61	$ 200.50	$ 268.85	$ 275.57	$ 282.08	$ 289.13
25	$ 188.96	$ 193.68	$ 196.39	$ 201.30	$ 269.93	$ 276.68	$ 283.21	$ 290.29
26	$ 192.73	$ 197.55	$ 200.30	$ 205.31	$ 275.30	$ 282.18	$ 288.85	$ 296.07
27	$ 197.24	$ 202.17	$ 205.00	$ 210.13	$ 281.75	$ 288.79	$ 295.62	$ 303.01
28	$ 204.58	$ 209.69	$ 212.63	$ 217.95	$ 292.24	$ 299.55	$ 306.62	$ 314.29
29	$ 210.61	$ 215.88	$ 218.89	$ 224.36	$ 300.84	$ 308.36	$ 315.65	$ 323.54
30	$ 213.62	$ 218.96	$ 222.02	$ 227.57	$ 305.14	$ 312.77	$ 320.16	$ 328.16
31	$ 218.14	$ 223.59	$ 226.71	$ 232.38	$ 311.60	$ 319.39	$ 326.93	$ 335.10
32	$ 222.65	$ 228.22	$ 231.41	$ 237.20	$ 318.05	$ 326.00	$ 333.70	$ 342.04
33	$ 225.48	$ 231.12	$ 234.34	$ 240.20	$ 322.08	$ 330.13	$ 337.93	$ 346.38
34	$ 228.49	$ 234.20	$ 237.47	$ 243.41	$ 326.38	$ 334.54	$ 342.45	$ 351.01
35	$ 229.99	$ 235.74	$ 239.04	$ 245.02	$ 328.53	$ 336.74	$ 344.70	$ 353.32
36	$ 231.50	$ 237.29	$ 240.60	$ 246.62	$ 330.69	$ 338.96	$ 346.96	$ 355.63
37	$ 233.00	$ 238.83	$ 242.17	$ 248.22	$ 332.84	$ 341.16	$ 349.22	$ 357.95
38	$ 234.51	$ 240.37	$ 243.73	$ 249.82	$ 334.99	$ 343.36	$ 351.47	$ 360.26
39	$ 237.52	$ 243.46	$ 246.86	$ 253.03	$ 339.29	$ 347.77	$ 355.98	$ 364.88
40	$ 240.53	$ 264.58	$ 249.99	$ 274.99	$ 343.59	$ 377.95	$ 360.50	$ 396.55
41	$ 245.05	$ 270.78	$ 254.68	$ 281.42	$ 350.04	$ 386.79	$ 367.27	$ 405.83
42	$ 249.38	$ 277.31	$ 259.18	$ 288.21	$ 356.23	$ 396.13	$ 373.76	$ 415.62
43	$ 255.40	$ 286.30	$ 265.44	$ 297.56	$ 364.83	$ 408.97	$ 382.78	$ 429.10
44	$ 262.93	$ 297.64	$ 273.27	$ 309.34	$ 375.58	$ 425.16	$ 394.07	$ 446.09
45	$ 271.78	$ 311.19	$ 282.46	$ 323.42	$ 388.22	$ 444.51	$ 407.32	$ 466.38
46	$ 282.32	$ 327.49	$ 293.42	$ 340.37	$ 403.28	$ 467.80	$ 423.12	$ 490.82
47	$ 294.17	$ 346.24	$ 305.74	$ 359.86	$ 420.21	$ 494.59	$ 440.89	$ 518.93
48	$ 307.72	$ 368.03	$ 319.82	$ 382.50	$ 439.57	$ 525.73	$ 461.20	$ 551.60
49	$ 321.09	$ 390.77	$ 333.71	$ 406.13	$ 458.66	$ 558.19	$ 481.23	$ 585.66
50	$ 336.14	$ 411.77	$ 349.36	$ 427.97	$ 480.17	$ 588.21	$ 503.79	$ 617.14
51	$ 351.01	$ 429.99	$ 364.81	$ 446.89	$ 501.41	$ 614.23	$ 526.08	$ 644.45
52	$ 367.39	$ 450.05	$ 381.83	$ 467.74	$ 524.80	$ 642.88	$ 550.62	$ 674.51
53	$ 383.95	$ 470.34	$ 399.04	$ 488.82	$ 548.45	$ 671.85	$ 575.44	$ 704.91
54	$ 401.83	$ 492.24	$ 417.63	$ 511.60	$ 573.99	$ 703.14	$ 602.24	$ 737.74
55	$ 419.71	$ 514.14	$ 436.21	$ 534.36	$ 599.54	$ 734.44	$ 629.04	$ 770.57
56	$ 439.09	$ 537.89	$ 456.36	$ 559.04	$ 627.23	$ 768.36	$ 658.09	$ 806.16
57	$ 458.67	$ 561.87	$ 476.70	$ 583.96	$ 655.19	$ 802.61	$ 687.43	$ 842.10
58	$ 479.56	$ 587.46	$ 498.41	$ 610.55	$ 685.03	$ 839.16	$ 718.74	$ 880.46
59	$ 489.91	$ 600.14	$ 509.17	$ 623.73	$ 699.82	$ 857.28	$ 734.25	$ 899.46
60	$ 510.80	$ 625.73	$ 530.89	$ 650.34	$ 729.66	$ 893.83	$ 765.57	$ 937.82
61	$ 528.87	$ 647.87	$ 549.66	$ 673.33	$ 755.47	$ 925.45	$ 792.64	$ 970.98
62	$ 540.73	$ 662.39	$ 561.99	$ 688.44	$ 772.41	$ 946.20	$ 810.42	$ 992.76
63	$ 555.60	$ 680.61	$ 577.44	$ 707.36	$ 793.65	$ 972.22	$ 832.70	$ 1,020.06
64+	$ 564.63	$ 691.67	$ 586.83	$ 718.87	$ 806.55	$ 988.02	$ 846.24	$ 1,036.64

PREMIUM RATES FOR YOUR COUNTY

(Use the Plan ID to find your plan on the Marketplace.)

Erie

	Silver		Gold	
	my Direct Blue Erie HMO Silver 0		my Direct Blue Erie HMO Gold 1000 - 2 Free PCP Visits	
Plan ID	38949PA0100004		38949PA0100006	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$ 229.48	$ 229.48	$ 218.25	$ 218.25
15	$ 249.88	$ 249.88	$ 237.65	$ 237.65
16	$ 257.67	$ 257.67	$ 245.06	$ 245.06
17	$ 265.47	$ 265.47	$ 252.48	$ 252.48
18	$ 273.87	$ 273.87	$ 260.47	$ 260.47
19	$ 282.27	$ 282.27	$ 268.46	$ 268.46
20	$ 290.97	$ 290.97	$ 276.73	$ 276.73
21	$ 299.97	$ 307.47	$ 285.29	$ 292.42
22	$ 299.97	$ 307.47	$ 285.29	$ 292.42
23	$ 299.97	$ 307.47	$ 285.29	$ 292.42
24	$ 299.97	$ 307.47	$ 285.29	$ 292.42
25	$ 301.17	$ 308.70	$ 286.43	$ 293.59
26	$ 307.17	$ 314.85	$ 292.14	$ 299.44
27	$ 314.37	$ 322.23	$ 298.98	$ 306.45
28	$ 326.07	$ 334.22	$ 310.11	$ 317.86
29	$ 335.67	$ 344.06	$ 319.24	$ 327.22
30	$ 340.47	$ 348.98	$ 323.80	$ 331.90
31	$ 347.67	$ 356.36	$ 330.65	$ 338.92
32	$ 354.86	$ 363.73	$ 337.50	$ 345.94
33	$ 359.36	$ 368.34	$ 341.78	$ 350.32
34	$ 364.16	$ 373.26	$ 346.34	$ 355.00
35	$ 366.56	$ 375.72	$ 348.62	$ 357.34
36	$ 368.96	$ 378.18	$ 350.91	$ 359.68
37	$ 371.36	$ 380.64	$ 353.19	$ 362.02
38	$ 373.76	$ 383.10	$ 355.47	$ 364.36
39	$ 378.56	$ 388.02	$ 360.04	$ 369.04
40	$ 383.36	$ 421.70	$ 364.60	$ 401.06
41	$ 390.56	$ 431.57	$ 371.45	$ 410.45
42	$ 397.46	$ 441.98	$ 378.01	$ 420.35
43	$ 407.06	$ 456.31	$ 387.14	$ 433.98
44	$ 419.06	$ 474.38	$ 398.55	$ 451.16
45	$ 433.16	$ 495.97	$ 411.96	$ 471.69
46	$ 449.96	$ 521.95	$ 427.94	$ 496.41
47	$ 468.85	$ 551.84	$ 445.91	$ 524.84
48	$ 490.45	$ 586.58	$ 466.45	$ 557.87
49	$ 511.75	$ 622.80	$ 486.70	$ 592.31
50	$ 535.75	$ 656.29	$ 509.53	$ 624.17
51	$ 559.44	$ 685.31	$ 532.07	$ 651.79
52	$ 585.54	$ 717.29	$ 556.89	$ 682.19
53	$ 611.94	$ 749.63	$ 581.99	$ 712.94
54	$ 640.44	$ 784.54	$ 609.09	$ 746.14
55	$ 668.93	$ 819.44	$ 636.20	$ 779.35
56	$ 699.83	$ 857.29	$ 665.58	$ 815.34
57	$ 731.03	$ 895.51	$ 695.25	$ 851.68
58	$ 764.32	$ 936.29	$ 726.92	$ 890.48
59	$ 780.82	$ 956.50	$ 742.61	$ 909.70
60	$ 814.12	$ 997.30	$ 774.28	$ 948.49
61	$ 842.92	$ 1,032.58	$ 801.66	$ 982.03
62	$ 861.81	$ 1,055.72	$ 819.64	$ 1,004.06
63	$ 885.51	$ 1,084.75	$ 842.18	$ 1,031.67
64+	$ 899.91	$ 1,102.39	$ 855.87	$ 1,048.44

PREMIUM RATES FOR YOUR COUNTY

(Use the Plan ID to find your plan on the Marketplace.)

Armstrong, Beaver, Butler, Clarion, Crawford, Forest, and Warren

	Catastrophic		Bronze		Bronze		Silver	
	Major Events Blue PPO, a Community Blue Plan 7900		my Direct Blue EPO Bronze 7900		my Direct Blue EPO Bronze 4000		my Direct Blue EPO Silver 4450 HSA	
Plan ID	33709PA0380004		33709PA0870008		33709PA0870007		33709PA0890001	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$175.54	$175.54	$206.40	$206.40	$222.97	$222.97	$291.89	$291.89
15	$191.14	$191.14	$224.74	$224.74	$242.79	$242.79	$317.83	$317.83
16	$197.11	$197.11	$231.76	$231.76	$250.37	$250.37	$327.75	$327.75
17	$203.07	$203.07	$238.77	$238.77	$257.95	$257.95	$337.67	$337.67
18	$209.50	$209.50	$246.33	$246.33	$266.11	$266.11	$348.36	$348.36
19	$215.92	$215.92	$253.88	$253.88	$274.27	$274.27	$359.04	$359.04
20	$222.58	$222.58	$261.71	$261.71	$282.73	$282.73	$370.10	$370.10
21	$229.46	$235.20	$269.80	$276.54	$291.47	$298.75	$381.55	$391.09
22	$229.46	$235.20	$269.80	$276.55	$291.47	$298.76	$381.55	$391.09
23	$229.46	$235.20	$269.80	$276.55	$291.47	$298.76	$381.55	$391.09
24	$229.46	$235.20	$269.80	$276.55	$291.47	$298.76	$381.55	$391.09
25	$230.38	$236.14	$270.88	$277.65	$292.64	$299.96	$383.08	$392.66
26	$234.97	$240.84	$276.28	$283.19	$298.47	$305.93	$390.71	$400.48
27	$240.47	$246.48	$282.75	$289.82	$305.46	$313.10	$399.86	$409.86
28	$249.42	$255.66	$293.27	$300.60	$316.83	$324.75	$414.74	$425.11
29	$256.77	$263.19	$301.91	$309.46	$326.15	$334.30	$426.95	$437.62
30	$260.44	$266.95	$306.22	$313.88	$330.82	$339.09	$433.06	$443.89
31	$265.94	$272.59	$312.70	$320.52	$337.81	$346.26	$442.22	$453.28
32	$271.45	$278.24	$319.17	$327.15	$344.81	$353.43	$451.37	$462.65
33	$274.89	$281.76	$323.22	$331.30	$349.18	$357.91	$457.10	$468.53
34	$278.56	$285.52	$327.54	$335.73	$353.84	$362.69	$463.20	$474.78
35	$280.40	$287.41	$329.70	$337.94	$356.18	$365.08	$466.25	$477.91
36	$282.24	$289.30	$331.85	$340.15	$358.51	$367.47	$469.31	$481.04
37	$284.07	$291.17	$334.01	$342.36	$360.84	$369.86	$472.36	$484.17
38	$285.91	$293.06	$336.17	$344.57	$363.17	$372.25	$475.41	$487.30
39	$289.58	$296.82	$340.49	$349.00	$367.84	$377.04	$481.52	$493.56
40	$293.25	$322.58	$344.80	$379.28	$372.50	$409.75	$487.62	$536.38
41	$298.76	$330.13	$351.28	$388.16	$379.49	$419.34	$496.78	$548.94
42	$304.03	$338.08	$357.49	$397.53	$386.20	$429.45	$505.55	$562.17
43	$311.38	$349.06	$366.12	$410.42	$395.52	$443.38	$517.76	$580.41
44	$320.56	$362.87	$376.91	$426.66	$407.18	$460.93	$533.03	$603.39
45	$331.34	$379.38	$389.59	$446.08	$420.88	$481.91	$550.96	$630.85
46	$344.19	$399.26	$404.70	$469.45	$437.21	$507.16	$572.33	$663.90
47	$358.65	$422.13	$421.70	$496.34	$455.57	$536.21	$596.36	$701.92
48	$375.17	$448.70	$441.12	$527.58	$476.55	$569.95	$623.83	$746.10
49	$391.46	$476.41	$460.28	$560.16	$497.25	$605.15	$650.92	$792.17
50	$409.82	$502.03	$481.86	$590.28	$520.57	$637.70	$681.45	$834.78
51	$427.94	$524.23	$503.18	$616.40	$543.59	$665.90	$711.59	$871.70
52	$447.91	$548.69	$526.65	$645.15	$568.95	$696.96	$744.79	$912.37
53	$468.10	$573.42	$550.39	$674.23	$594.60	$728.39	$778.36	$953.49
54	$489.90	$600.13	$576.02	$705.62	$622.29	$762.31	$814.61	$997.90
55	$511.70	$626.83	$601.65	$737.02	$649.98	$796.23	$850.86	$1,042.30
56	$535.33	$655.78	$629.44	$771.06	$680.00	$833.00	$890.16	$1,090.45
57	$559.19	$685.01	$657.50	$805.44	$710.31	$870.13	$929.84	$1,139.05
58	$584.66	$716.21	$687.45	$842.13	$742.67	$909.77	$972.19	$1,190.93
59	$597.28	$731.67	$702.29	$860.31	$758.70	$929.41	$993.17	$1,216.63
60	$622.75	$762.87	$732.24	$896.99	$791.05	$969.04	$1,035.53	$1,268.52
61	$644.78	$789.86	$758.14	$928.72	$819.03	$1,003.31	$1,072.16	$1,313.40
62	$659.24	$807.57	$775.14	$949.55	$837.39	$1,025.80	$1,096.19	$1,342.83
63	$677.37	$829.78	$796.45	$975.65	$860.42	$1,054.01	$1,126.34	$1,379.77
64+	$688.38	$843.27	$809.40	$991.52	$874.41	$1,071.15	$1,144.65	$1,402.20

PREMIUM RATES FOR YOUR COUNTY

(Use the Plan ID to find your plan on the Marketplace.)

Armstrong, Beaver, Butler, Clarion, Crawford, Forest, and Warren

	Silver		Silver		Gold	
	my Direct Blue EPO Silver 2400 - 2 Free PCP Visits		my Direct Blue EPO Silver 0		my Direct Blue EPO Gold 1000 - 2 Free PCP Visits	
Plan ID	33709PA0870002		33709PA0870009		33709PA0870001	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$306.24	$306.24	$325.66	$325.66	$306.87	$306.87
15	$333.46	$333.46	$354.61	$354.61	$334.15	$334.15
16	$343.87	$343.87	$365.68	$365.68	$344.58	$344.58
17	$354.27	$354.27	$376.74	$376.74	$355.01	$355.01
18	$365.48	$365.48	$388.66	$388.66	$366.24	$366.24
19	$376.69	$376.69	$400.58	$400.58	$377.47	$377.47
20	$388.30	$388.30	$412.93	$412.93	$389.11	$389.11
21	$400.31	$410.32	$425.70	$436.35	$401.14	$411.17
22	$400.31	$410.32	$425.70	$436.34	$401.14	$411.17
23	$400.31	$410.32	$425.70	$436.34	$401.14	$411.17
24	$400.31	$410.32	$425.70	$436.34	$401.14	$411.17
25	$401.91	$411.96	$427.40	$438.09	$402.74	$412.81
26	$409.92	$420.17	$435.92	$446.82	$410.77	$421.04
27	$419.52	$430.01	$446.13	$457.28	$420.39	$430.90
28	$435.14	$446.02	$462.74	$474.31	$436.04	$446.94
29	$447.95	$459.15	$476.36	$488.27	$448.88	$460.10
30	$454.35	$465.71	$483.17	$495.25	$455.29	$466.67
31	$463.96	$475.56	$493.39	$505.72	$464.92	$476.54
32	$473.57	$485.41	$503.60	$516.19	$474.55	$486.41
33	$479.57	$491.56	$509.99	$522.74	$480.57	$492.58
34	$485.98	$498.13	$516.80	$529.72	$486.98	$499.15
35	$489.18	$501.41	$520.21	$533.22	$490.19	$502.44
36	$492.38	$504.69	$523.61	$536.70	$493.40	$505.74
37	$495.58	$507.97	$527.02	$540.20	$496.61	$509.03
38	$498.79	$511.26	$530.42	$543.68	$499.82	$512.32
39	$505.19	$517.82	$537.23	$550.66	$506.24	$518.90
40	$511.60	$562.76	$544.04	$598.44	$512.66	$563.93
41	$521.20	$575.93	$554.26	$612.46	$522.28	$577.12
42	$530.41	$589.82	$564.05	$627.22	$531.51	$591.04
43	$543.22	$608.95	$577.67	$647.57	$544.35	$610.22
44	$559.23	$633.05	$594.70	$673.20	$560.39	$634.36
45	$578.05	$661.87	$614.71	$703.84	$579.25	$663.24
46	$600.47	$696.55	$638.55	$740.72	$601.71	$697.98
47	$625.68	$736.43	$665.37	$783.14	$626.98	$737.96
48	$654.51	$782.79	$696.02	$832.44	$655.86	$784.41
49	$682.93	$831.13	$726.24	$883.83	$684.34	$832.84
50	$714.95	$875.81	$760.30	$931.37	$716.44	$877.64
51	$746.58	$914.56	$793.93	$972.56	$748.13	$916.46
52	$781.41	$957.23	$830.97	$1,017.94	$783.03	$959.21
53	$816.63	$1,000.37	$868.43	$1,063.83	$818.33	$1,002.45
54	$854.66	$1,046.96	$908.87	$1,113.37	$856.43	$1,049.13
55	$892.69	$1,093.55	$949.31	$1,162.90	$894.54	$1,095.81
56	$933.92	$1,144.05	$993.16	$1,216.62	$935.86	$1,146.43
57	$975.56	$1,195.06	$1,037.43	$1,270.85	$977.58	$1,197.54
58	$1,019.99	$1,249.49	$1,084.68	$1,328.73	$1,022.10	$1,252.07
59	$1,042.01	$1,276.46	$1,108.10	$1,357.42	$1,044.17	$1,279.11
60	$1,086.44	$1,330.89	$1,155.35	$1,415.30	$1,088.69	$1,333.65
61	$1,124.87	$1,377.97	$1,196.22	$1,465.37	$1,127.20	$1,380.82
62	$1,150.09	$1,408.86	$1,223.04	$1,498.22	$1,152.48	$1,411.79
63	$1,181.72	$1,447.61	$1,256.67	$1,539.42	$1,184.17	$1,450.61
64+	$1,200.93	$1,471.14	$1,277.10	$1,564.45	$1,203.42	$1,474.19

PREMIUM RATES FOR YOUR COUNTY

(Use the Plan ID to find your plan on the Marketplace.)

Blair, Cambria, and Somerset

Catastrophic		Bronze		Bronze		Silver	
Major Events Blue PPO, a Community Blue Plan 7900		my Direct Blue Conemaugh EPO Bronze 7900		my Direct Blue Conemaugh EPO Bronze 4000		my Direct Blue Conemaugh EPO Silver 4450 HSA	
33709PA0380004		33709PA0860008		33709PA0860007		33709PA0880001	
No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco
$175.54	$175.54	$206.40	$206.40	$222.97	$222.97	$291.89	$291.89
$191.14	$191.14	$224.74	$224.74	$242.79	$242.79	$317.83	$317.83
$197.11	$197.11	$231.76	$231.76	$250.37	$250.37	$327.75	$327.75
$203.07	$203.07	$238.77	$238.77	$257.95	$257.95	$337.67	$337.67
$209.50	$209.50	$246.33	$246.33	$266.11	$266.11	$348.36	$348.36
$215.92	$215.92	$253.88	$253.88	$274.27	$274.27	$359.04	$359.04
$222.58	$222.58	$261.71	$261.71	$282.73	$282.73	$370.10	$370.10
$229.46	$235.20	$269.80	$276.54	$291.47	$298.75	$381.55	$391.09
$229.46	$235.20	$269.80	$276.55	$291.47	$298.76	$381.55	$391.09
$229.46	$235.20	$269.80	$276.55	$291.47	$298.76	$381.55	$391.09
$229.46	$235.20	$269.80	$276.55	$291.47	$298.76	$381.55	$391.09
$230.38	$236.14	$270.88	$277.65	$292.64	$299.96	$383.08	$392.66
$234.97	$240.84	$276.28	$283.19	$298.47	$305.93	$390.71	$400.48
$240.47	$246.48	$282.75	$289.82	$305.46	$313.10	$399.86	$409.86
$249.42	$255.66	$293.27	$300.60	$316.83	$324.75	$414.74	$425.11
$256.77	$263.19	$301.91	$309.46	$326.15	$334.30	$426.95	$437.62
$260.44	$266.95	$306.22	$313.88	$330.82	$339.09	$433.06	$443.89
$265.94	$272.59	$312.70	$320.52	$337.81	$346.26	$442.22	$453.28
$271.45	$278.24	$319.17	$327.15	$344.81	$353.43	$451.37	$462.65
$274.89	$281.76	$323.22	$331.30	$349.18	$357.91	$457.10	$468.53
$278.56	$285.52	$327.54	$335.73	$353.84	$362.69	$463.20	$474.78
$280.40	$287.41	$329.70	$337.94	$356.18	$365.08	$466.25	$477.91
$282.24	$289.30	$331.85	$340.15	$358.51	$367.47	$469.31	$481.04
$284.07	$291.17	$334.01	$342.36	$360.84	$369.86	$472.36	$484.17
$285.91	$293.06	$336.17	$344.57	$363.17	$372.25	$475.41	$487.30
$289.58	$296.82	$340.49	$349.00	$367.84	$377.04	$481.52	$493.56
$293.25	$322.58	$344.80	$379.28	$372.50	$409.75	$487.62	$536.38
$298.76	$330.13	$351.28	$388.16	$379.49	$419.34	$496.78	$548.94
$304.03	$338.08	$357.49	$397.53	$386.20	$429.45	$505.55	$562.17
$311.38	$349.06	$366.12	$410.42	$395.52	$443.38	$517.76	$580.41
$320.56	$362.87	$376.91	$426.66	$407.18	$460.93	$533.03	$603.39
$331.34	$379.38	$389.59	$446.08	$420.88	$481.91	$550.96	$630.85
$344.19	$399.26	$404.70	$469.45	$437.21	$507.16	$572.33	$663.90
$358.65	$422.13	$421.70	$496.34	$455.57	$536.21	$596.36	$701.92
$375.17	$448.70	$441.12	$527.58	$476.55	$569.95	$623.83	$746.10
$391.46	$476.41	$460.28	$560.16	$497.25	$605.15	$650.92	$792.17
$409.82	$502.03	$481.86	$590.28	$520.57	$637.70	$681.45	$834.78
$427.94	$524.23	$503.18	$616.40	$543.59	$665.90	$711.59	$871.70
$447.91	$548.69	$526.65	$645.15	$568.95	$696.96	$744.79	$912.37
$468.10	$573.42	$550.39	$674.23	$594.60	$728.39	$778.36	$953.49
$489.90	$600.13	$576.02	$705.62	$622.29	$762.31	$814.61	$997.90
$511.70	$626.83	$601.65	$737.02	$649.98	$796.23	$850.86	$1,042.30
$535.33	$655.78	$629.44	$771.06	$680.00	$833.00	$890.16	$1,090.45
$559.19	$685.01	$657.50	$805.44	$710.31	$870.13	$929.84	$1,139.05
$584.66	$716.21	$687.45	$842.13	$742.67	$909.77	$972.19	$1,190.93
$597.28	$731.67	$702.29	$860.31	$758.70	$929.41	$993.17	$1,216.63
$622.75	$762.87	$732.24	$896.99	$791.05	$969.04	$1,035.53	$1,268.52
$644.78	$789.86	$758.14	$928.72	$819.03	$1,003.31	$1,072.16	$1,313.40
$659.24	$807.57	$775.14	$949.55	$837.39	$1,025.80	$1,096.19	$1,342.83
$677.37	$829.78	$796.45	$975.65	$860.42	$1,054.01	$1,126.34	$1,379.77
$688.38	$843.27	$809.40	$991.52	$874.41	$1,071.15	$1,144.65	$1,402.20

PREMIUM RATES FOR YOUR COUNTY

(Use the Plan ID to find your plan on the Marketplace.)

Blair, Cambria, and Somerset

	Silver		Silver		Gold	
	my Direct Blue Conemaugh EPO Silver 2400 - 2 Free PCP Visits		my Direct Blue Conemaugh EPO Silver 0		my Direct Blue Conemaugh EPO Gold 1000 - 2 Free PCP Visits	
Plan ID	33709PA0860002		33709PA0860009		33709PA0860001	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$306.24	$306.24	$325.66	$325.66	$306.87	306.87
15	$333.46	$333.46	$354.61	$354.61	$334.15	334.15
16	$343.87	$343.87	$365.68	$365.68	$344.58	344.58
17	$354.27	$354.27	$376.74	$376.74	$355.01	355.01
18	$365.48	$365.48	$388.66	$388.66	$366.24	366.24
19	$376.69	$376.69	$400.58	$400.58	$377.47	377.47
20	$388.30	$388.30	$412.93	$412.93	$389.11	389.11
21	$400.31	$410.32	$425.70	$436.35	$401.14	411.17
22	$400.31	$410.32	$425.70	$436.34	$401.14	411.17
23	$400.31	$410.32	$425.70	$436.34	$401.14	411.17
24	$400.31	$410.32	$425.70	$436.34	$401.14	411.17
25	$401.91	$411.96	$427.40	$438.09	$402.74	412.81
26	$409.92	$420.17	$435.92	$446.82	$410.77	421.04
27	$419.52	$430.01	$446.13	$457.28	$420.39	430.9
28	$435.14	$446.02	$462.74	$474.31	$436.04	446.94
29	$447.95	$459.15	$476.36	$488.27	$448.88	460.1
30	$454.35	$465.71	$483.17	$495.25	$455.29	466.67
31	$463.96	$475.56	$493.39	$505.72	$464.92	476.54
32	$473.57	$485.41	$503.60	$516.19	$474.55	486.41
33	$479.57	$491.56	$509.99	$522.74	$480.57	492.58
34	$485.98	$498.13	$516.80	$529.72	$486.98	499.15
35	$489.18	$501.41	$520.21	$533.22	$490.19	502.44
36	$492.38	$504.69	$523.61	$536.70	$493.40	505.74
37	$495.58	$507.97	$527.02	$540.20	$496.61	509.03
38	$498.79	$511.26	$530.42	$543.68	$499.82	512.32
39	$505.19	$517.82	$537.23	$550.66	$506.24	518.9
40	$511.60	$562.76	$544.04	$598.44	$512.66	563.93
41	$521.20	$575.93	$554.26	$612.46	$522.28	577.12
42	$530.41	$589.82	$564.05	$627.22	$531.51	591.04
43	$543.22	$608.95	$577.67	$647.57	$544.35	610.22
44	$559.23	$633.05	$594.70	$673.20	$560.39	634.36
45	$578.05	$661.87	$614.71	$703.84	$579.25	663.24
46	$600.47	$696.55	$638.55	$740.72	$601.71	697.98
47	$625.68	$736.43	$665.37	$783.14	$626.98	737.96
48	$654.51	$782.79	$696.02	$832.44	$655.86	784.41
49	$682.93	$831.13	$726.24	$883.83	$684.34	832.84
50	$714.95	$875.81	$760.30	$931.37	$716.44	877.64
51	$746.58	$914.56	$793.93	$972.56	$748.13	916.46
52	$781.41	$957.23	$830.97	$1,017.94	$783.03	959.21
53	$816.63	$1,000.37	$868.43	$1,063.83	$818.33	1002.45
54	$854.66	$1,046.96	$908.87	$1,113.37	$856.43	1049.13
55	$892.69	$1,093.55	$949.31	$1,162.90	$894.54	1095.81
56	$933.92	$1,144.05	$993.16	$1,216.62	$935.86	1146.43
57	$975.56	$1,195.06	$1,037.43	$1,270.85	$977.58	1197.54
58	$1,019.99	$1,249.49	$1,084.68	$1,328.73	$1,022.10	1252.07
59	$1,042.01	$1,276.46	$1,108.10	$1,357.42	$1,044.17	1279.11
60	$1,086.44	$1,330.89	$1,155.35	$1,415.30	$1,088.69	1333.65
61	$1,124.87	$1,377.97	$1,196.22	$1,465.37	$1,127.20	1380.82
62	$1,150.09	$1,408.86	$1,223.04	$1,498.22	$1,152.48	1411.79
63	$1,181.72	$1,447.61	$1,256.67	$1,539.42	$1,184.17	1450.61
64+	$1,200.93	$1,471.14	$1,277.10	$1,564.45	$1,203.42	1474.19

BASE RATES FOR YOUR COUNTY

These plans are only available directly through Highmark in some western Pennsylvania counties. They are not available on the Marketplace.

Allegheny, Washington, and Westmoreland

	Catastrophic		Bronze		Silver	
	Major Events Blue PPO, a Community Blue Plan 7900		Shared Cost Blue PPO Bronze 7500		my Direct Blue HMO Silver 3500 - 2 Free PCP Visits	
Plan ID	33709PA0380003		70194PA0260001		38949PA0080010	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$175.54	$175.54	$274.12	$274.12	$246.23	$246.23
15	$191.14	$191.14	$298.49	$298.49	$268.12	$268.12
16	$197.11	$197.11	$307.81	$307.81	$276.49	$276.49
17	$203.07	$203.07	$317.12	$317.12	$284.85	$284.85
18	$209.50	$209.50	$327.16	$327.16	$293.87	$293.87
19	$215.92	$215.92	$337.19	$337.19	$302.88	$302.88
20	$222.58	$222.58	$347.58	$347.58	$312.21	$312.21
21	$229.46	$235.20	$358.33	$367.29	$321.87	$329.91
22	$229.46	$235.20	$358.33	$367.29	$321.87	$329.92
23	$229.46	$235.20	$358.33	$367.29	$321.87	$329.92
24	$229.46	$235.20	$358.33	$367.29	$321.87	$329.92
25	$230.38	$236.14	$359.76	$368.75	$323.16	$331.24
26	$234.97	$240.84	$366.93	$376.10	$329.59	$337.83
27	$240.47	$246.48	$375.53	$384.92	$337.32	$345.75
28	$249.42	$255.66	$389.50	$399.24	$349.87	$358.62
29	$256.77	$263.19	$400.97	$410.99	$360.17	$369.17
30	$260.44	$266.95	$406.70	$416.87	$365.32	$374.45
31	$265.94	$272.59	$415.30	$425.68	$373.05	$382.38
32	$271.45	$278.24	$423.90	$434.50	$380.77	$390.29
33	$274.89	$281.76	$429.28	$440.01	$385.60	$395.24
34	$278.56	$285.52	$435.01	$445.89	$390.75	$400.52
35	$280.40	$287.41	$437.88	$448.83	$393.33	$403.16
36	$282.24	$289.30	$440.75	$451.77	$395.90	$405.80
37	$284.07	$291.17	$443.61	$454.70	$398.48	$408.44
38	$285.91	$293.06	$446.48	$457.64	$401.05	$411.08
39	$289.58	$296.82	$452.21	$463.52	$406.20	$416.36
40	$293.25	$322.58	$457.95	$503.75	$411.35	$452.49
41	$298.76	$330.13	$466.55	$515.54	$419.07	$463.07
42	$304.03	$338.08	$474.79	$527.97	$426.48	$474.25
43	$311.38	$349.06	$486.25	$545.09	$436.78	$489.63
44	$320.56	$362.87	$500.59	$566.67	$449.65	$509.00
45	$331.34	$379.38	$517.43	$592.46	$464.78	$532.17
46	$344.19	$399.26	$537.50	$623.50	$482.81	$560.06
47	$358.65	$422.13	$560.07	$659.20	$503.08	$592.13
48	$375.17	$448.70	$585.87	$700.70	$526.26	$629.41
49	$391.46	$476.41	$611.31	$743.96	$549.11	$668.27
50	$409.82	$502.03	$639.98	$783.98	$574.86	$704.20
51	$427.94	$524.23	$668.29	$818.66	$600.29	$735.36
52	$447.91	$548.69	$699.46	$856.84	$628.29	$769.66
53	$468.10	$573.42	$730.99	$895.46	$656.61	$804.35
54	$489.90	$600.13	$765.03	$937.16	$687.19	$841.81
55	$511.70	$626.83	$799.08	$978.87	$717.77	$879.27
56	$535.33	$655.78	$835.98	$1,024.08	$750.92	$919.88
57	$559.19	$685.01	$873.25	$1,069.73	$784.40	$960.89
58	$584.66	$716.21	$913.02	$1,118.45	$820.12	$1,004.65
59	$597.28	$731.67	$932.73	$1,142.59	$837.83	$1,026.34
60	$622.75	$762.87	$972.51	$1,191.32	$873.56	$1,070.11
61	$644.78	$789.86	$1,006.91	$1,233.46	$904.45	$1,107.95
62	$659.24	$807.57	$1,029.48	$1,261.11	$924.73	$1,132.79
63	$677.37	$829.78	$1,057.79	$1,295.79	$950.16	$1,163.95
64+	$688.38	$843.27	$1,074.99	$1,316.86	$965.61	$1,182.87

BASE RATES FOR YOUR COUNTY

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Erie

	Catastrophic		Bronze		Silver	
	Major Events Blue PPO, a Community Blue Plan 7900		Shared Cost Blue PPO Bronze 7500		my Direct Blue Erie HMO Silver 3500 - 2 Free PCP Visits	
Plan ID	33709PA0380003		70194PA0260001		38949PA0100005	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$175.54	$175.54	$274.12	$274.12	$175.86	$175.86
15	$191.14	$191.14	$298.49	$298.49	$191.49	$191.49
16	$197.11	$197.11	$307.81	$307.81	$197.47	$197.47
17	$203.07	$203.07	$317.12	$317.12	$203.44	$203.44
18	$209.50	$209.50	$327.16	$327.16	$209.88	$209.88
19	$215.92	$215.92	$337.19	$337.19	$216.32	$216.32
20	$222.58	$222.58	$347.58	$347.58	$222.98	$222.98
21	$229.46	$235.20	$358.33	$367.29	$229.88	$235.63
22	$229.46	$235.20	$358.33	$367.29	$229.88	$235.63
23	$229.46	$235.20	$358.33	$367.29	$229.88	$235.63
24	$229.46	$235.20	$358.33	$367.29	$229.88	$235.63
25	$230.38	$236.14	$359.76	$368.75	$230.80	$236.57
26	$234.97	$240.84	$366.93	$376.10	$235.40	$241.29
27	$240.47	$246.48	$375.53	$384.92	$240.91	$246.93
28	$249.42	$255.66	$389.50	$399.24	$249.88	$256.13
29	$256.77	$263.19	$400.97	$410.99	$257.24	$263.67
30	$260.44	$266.95	$406.70	$416.87	$260.91	$267.43
31	$265.94	$272.59	$415.30	$425.68	$266.43	$273.09
32	$271.45	$278.24	$423.90	$434.50	$271.95	$278.75
33	$274.89	$281.76	$429.28	$440.01	$275.40	$282.29
34	$278.56	$285.52	$435.01	$445.89	$279.07	$286.05
35	$280.40	$287.41	$437.88	$448.83	$280.91	$287.93
36	$282.24	$289.30	$440.75	$451.77	$282.75	$289.82
37	$284.07	$291.17	$443.61	$454.70	$284.59	$291.70
38	$285.91	$293.06	$446.48	$457.64	$286.43	$293.59
39	$289.58	$296.82	$452.21	$463.52	$290.11	$297.36
40	$293.25	$322.58	$457.95	$503.75	$293.79	$323.17
41	$298.76	$330.13	$466.55	$515.54	$299.30	$330.73
42	$304.03	$338.08	$474.79	$527.97	$304.59	$338.70
43	$311.38	$349.06	$486.25	$545.09	$311.95	$349.70
44	$320.56	$362.87	$500.59	$566.67	$321.14	$363.53
45	$331.34	$379.38	$517.43	$592.46	$331.95	$380.08
46	$344.19	$399.26	$537.50	$623.50	$344.82	$399.99
47	$358.65	$422.13	$560.07	$659.20	$359.30	$422.90
48	$375.17	$448.70	$585.87	$700.70	$375.85	$449.52
49	$391.46	$476.41	$611.31	$743.96	$392.18	$477.28
50	$409.82	$502.03	$639.98	$783.98	$410.57	$502.95
51	$427.94	$524.23	$668.29	$818.66	$428.73	$525.19
52	$447.91	$548.69	$699.46	$856.84	$448.73	$549.69
53	$468.10	$573.42	$730.99	$895.46	$468.96	$574.48
54	$489.90	$600.13	$765.03	$937.16	$490.79	$601.22
55	$511.70	$626.83	$799.08	$978.87	$512.63	$627.97
56	$535.33	$655.78	$835.98	$1,024.08	$536.31	$656.98
57	$559.19	$685.01	$873.25	$1,069.73	$560.22	$686.27
58	$584.66	$716.21	$913.02	$1,118.45	$585.73	$717.52
59	$597.28	$731.67	$932.73	$1,142.59	$598.38	$733.02
60	$622.75	$762.87	$972.51	$1,191.32	$623.89	$764.27
61	$644.78	$789.86	$1,006.91	$1,233.46	$645.96	$791.30
62	$659.24	$807.57	$1,029.48	$1,261.11	$660.45	$809.05
63	$677.37	$829.78	$1,057.79	$1,295.79	$678.61	$831.30
64+	$688.38	$843.27	$1,074.99	$1,316.86	$689.64	$844.81

BASE RATES FOR YOUR COUNTY

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Armstrong, Beaver, Butler, Clarion, Crawford, Forest, Warren

	Bronze		Silver	
	Shared Cost Blue PPO Bronze 7500		my Direct Blue EPO Silver 3500 - 2 Free PCP Visits	
Plan ID	70194PA0260001		33709PA0870010	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$274.12	$274.12	$249.57	$249.57
15	$298.49	$298.49	$271.75	$271.75
16	$307.81	$307.81	$280.23	$280.23
17	$317.12	$317.12	$288.71	$288.71
18	$327.16	$327.16	$297.85	$297.85
19	$337.19	$337.19	$306.98	$306.98
20	$347.58	$347.58	$316.44	$316.44
21	$358.33	$367.29	$326.23	$334.39
22	$358.33	$367.29	$326.23	$334.39
23	$358.33	$367.29	$326.23	$334.39
24	$358.33	$367.29	$326.23	$334.39
25	$359.76	$368.75	$327.53	$335.72
26	$366.93	$376.10	$334.06	$342.41
27	$375.53	$384.92	$341.89	$350.44
28	$389.50	$399.24	$354.61	$363.48
29	$400.97	$410.99	$365.05	$374.18
30	$406.70	$416.87	$370.27	$379.53
31	$415.30	$425.68	$378.10	$387.55
32	$423.90	$434.50	$385.93	$395.58
33	$429.28	$440.01	$390.82	$400.59
34	$435.01	$445.89	$396.04	$405.94
35	$437.88	$448.83	$398.65	$408.62
36	$440.75	$451.77	$401.26	$411.29
37	$443.61	$454.70	$403.87	$413.97
38	$446.48	$457.64	$406.48	$416.64
39	$452.21	$463.52	$411.70	$421.99
40	$457.95	$503.75	$416.92	$458.61
41	$466.55	$515.54	$424.75	$469.35
42	$474.79	$527.97	$432.25	$480.66
43	$486.25	$545.09	$442.69	$496.26
44	$500.59	$566.67	$455.74	$515.90
45	$517.43	$592.46	$471.08	$539.39
46	$537.50	$623.50	$489.35	$567.65
47	$560.07	$659.20	$509.90	$600.15
48	$585.87	$700.70	$533.39	$637.93
49	$611.31	$743.96	$556.55	$677.32
50	$639.98	$783.98	$582.65	$713.75
51	$668.29	$818.66	$608.42	$745.31
52	$699.46	$856.84	$636.80	$780.08
53	$730.99	$895.46	$665.51	$815.25
54	$765.03	$937.16	$696.50	$853.21
55	$799.08	$978.87	$727.49	$891.18
56	$835.98	$1,024.08	$761.09	$932.34
57	$873.25	$1,069.73	$795.02	$973.90
58	$913.02	$1,118.45	$831.23	$1,018.26
59	$932.73	$1,142.59	$849.18	$1,040.25
60	$972.51	$1,191.32	$885.39	$1,084.60
61	$1,006.91	$1,233.46	$916.71	$1,122.97
62	$1,029.48	$1,261.11	$937.26	$1,148.14
63	$1,057.79	$1,295.79	$963.03	$1,179.71
64+	$1,074.99	$1,316.86	$978.69	$1,198.90

BASE RATES FOR YOUR COUNTY

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Blair, Cambria, Somerset

	Silver		Bronze	
	my Direct Blue Conemaugh EPO Silver 3500 - 2 Free PCP Visits		Shared Cost Blue PPO Bronze 7500	
Plan ID	33709PA0860010		70194PA0260001	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$249.57	$249.57	$274.12	$274.12
15	$271.75	$271.75	$298.49	$298.49
16	$280.23	$280.23	$307.81	$307.81
17	$288.71	$288.71	$317.12	$317.12
18	$297.85	$297.85	$327.16	$327.16
19	$306.98	$306.98	$337.19	$337.19
20	$316.44	$316.44	$347.58	$347.58
21	$326.23	$334.39	$358.33	$367.29
22	$326.23	$334.39	$358.33	$367.29
23	$326.23	$334.39	$358.33	$367.29
24	$326.23	$334.39	$358.33	$367.29
25	$327.53	$335.72	$359.76	$368.75
26	$334.06	$342.41	$366.93	$376.10
27	$341.89	$350.44	$375.53	$384.92
28	$354.61	$363.48	$389.50	$399.24
29	$365.05	$374.18	$400.97	$410.99
30	$370.27	$379.53	$406.70	$416.87
31	$378.10	$387.55	$415.30	$425.68
32	$385.93	$395.58	$423.90	$434.50
33	$390.82	$400.59	$429.28	$440.01
34	$396.04	$405.94	$435.01	$445.89
35	$398.65	$408.62	$437.88	$448.83
36	$401.26	$411.29	$440.75	$451.77
37	$403.87	$413.97	$443.61	$454.70
38	$406.48	$416.64	$446.48	$457.64
39	$411.70	$421.99	$452.21	$463.52
40	$416.92	$458.61	$457.95	$503.75
41	$424.75	$469.35	$466.55	$515.54
42	$432.25	$480.66	$474.79	$527.97
43	$442.69	$496.26	$486.25	$545.09
44	$455.74	$515.90	$500.59	$566.67
45	$471.08	$539.39	$517.43	$592.46
46	$489.35	$567.65	$537.50	$623.50
47	$509.90	$600.15	$560.07	$659.20
48	$533.39	$637.93	$585.87	$700.70
49	$556.55	$677.32	$611.31	$743.96
50	$582.65	$713.75	$639.98	$783.98
51	$608.42	$745.31	$668.29	$818.66
52	$636.80	$780.08	$699.46	$856.84
53	$665.51	$815.25	$730.99	$895.46
54	$696.50	$853.21	$765.03	$937.16
55	$727.49	$891.18	$799.08	$978.87
56	$761.09	$932.34	$835.98	$1,024.08
57	$795.02	$973.90	$873.25	$1,069.73
58	$831.23	$1,018.26	$913.02	$1,118.45
59	$849.18	$1,040.25	$932.73	$1,142.59
60	$885.39	$1,084.60	$972.51	$1,191.32
61	$916.71	$1,122.97	$1,006.91	$1,233.46
62	$937.26	$1,148.14	$1,029.48	$1,261.11
63	$963.03	$1,179.71	$1,057.79	$1,295.79
64+	$978.69	$1,198.90	$1,074.99	$1,316.86

BASE RATES FOR YOUR COUNTY

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Bedford, Cameron, Clearfield, Elk, Fayette, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, and Venango

	Catastrophic		Bronze	
	Major Events Blue PPO, a Community Blue Plan 7900		Shared Cost Blue PPO Bronze 7500	
Plan ID	33709PA0380003		70194PA0260001	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$175.54	$175.54	$274.12	$274.12
15	$191.14	$191.14	$298.49	$298.49
16	$197.11	$197.11	$307.81	$307.81
17	$203.07	$203.07	$317.12	$317.12
18	$209.50	$209.50	$327.16	$327.16
19	$215.92	$215.92	$337.19	$337.19
20	$222.58	$222.58	$347.58	$347.58
21	$229.46	$235.20	$358.33	$367.29
22	$229.46	$235.20	$358.33	$367.29
23	$229.46	$235.20	$358.33	$367.29
24	$229.46	$235.20	$358.33	$367.29
25	$230.38	$236.14	$359.76	$368.75
26	$234.97	$240.84	$366.93	$376.10
27	$240.47	$246.48	$375.53	$384.92
28	$249.42	$255.66	$389.50	$399.24
29	$256.77	$263.19	$400.97	$410.99
30	$260.44	$266.95	$406.70	$416.87
31	$265.94	$272.59	$415.30	$425.68
32	$271.45	$278.24	$423.90	$434.50
33	$274.89	$281.76	$429.28	$440.01
34	$278.56	$285.52	$435.01	$445.89
35	$280.40	$287.41	$437.88	$448.83
36	$282.24	$289.30	$440.75	$451.77
37	$284.07	$291.17	$443.61	$454.70
38	$285.91	$293.06	$446.48	$457.64
39	$289.58	$296.82	$452.21	$463.52
40	$293.25	$322.58	$457.95	$503.75
41	$298.76	$330.13	$466.55	$515.54
42	$304.03	$338.08	$474.79	$527.97
43	$311.38	$349.06	$486.25	$545.09
44	$320.56	$362.87	$500.59	$566.67
45	$331.34	$379.38	$517.43	$592.46
46	$344.19	$399.26	$537.50	$623.50
47	$358.65	$422.13	$560.07	$659.20
48	$375.17	$448.70	$585.87	$700.70
49	$391.46	$476.41	$611.31	$743.96
50	$409.82	$502.03	$639.98	$783.98
51	$427.94	$524.23	$668.29	$818.66
52	$447.91	$548.69	$699.46	$856.84
53	$468.10	$573.42	$730.99	$895.46
54	$489.90	$600.13	$765.03	$937.16
55	$511.70	$626.83	$799.08	$978.87
56	$535.33	$655.78	$835.98	$1,024.08
57	$559.19	$685.01	$873.25	$1,069.73
58	$584.66	$716.21	$913.02	$1,118.45
59	$597.28	$731.67	$932.73	$1,142.59
60	$622.75	$762.87	$972.51	$1,191.32
61	$644.78	$789.86	$1,006.91	$1,233.46
62	$659.24	$807.57	$1,029.48	$1,261.11
63	$677.37	$829.78	$1,057.79	$1,295.79
64+	$688.38	$843.27	$1,074.99	$1,316.86

BASE RATES FOR CENTRE COUNTY

These plans are only available directly through Highmark in some western Pennsylvania counties. They are not available on the Marketplace.

*NOTE: YOU MUST RESIDE IN ONE OF THE FOLLOWING ZIP CODES IN CENTRE COUNTY TO ENROLL IN ONE OF THESE PLANS:

16677, 16686, 16829, 16845, 16859, 16866, 16874

Centre

	Catastrophic		Bronze	
	Major Events Blue PPO, a Community Blue Plan 7900		Shared Cost Blue PPO Bronze 7500	
Plan ID	33709PA0380003		70194PA0260001	
Age	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	$ 188.21	$ 188.21	$ 293.91	$ 293.91
15	$ 204.93	$ 204.93	$ 320.03	$ 320.03
16	$ 211.33	$ 211.33	$ 330.02	$ 330.02
17	$ 217.73	$ 217.73	$ 340.01	$ 340.01
18	$ 224.62	$ 224.62	$ 350.77	$ 350.77
19	$ 231.50	$ 231.50	$ 361.52	$ 361.52
20	$ 238.64	$ 238.64	$ 372.66	$ 372.66
21	$ 246.02	$ 252.17	$ 384.19	$ 393.79
22	$ 246.02	$ 252.17	$ 384.19	$ 393.79
23	$ 246.02	$ 252.17	$ 384.19	$ 393.79
24	$ 246.02	$ 252.17	$ 384.19	$ 393.79
25	$ 247.00	$ 253.18	$ 385.73	$ 395.37
26	$ 251.92	$ 258.22	$ 393.41	$ 403.25
27	$ 257.83	$ 264.28	$ 402.63	$ 412.70
28	$ 267.42	$ 274.11	$ 417.61	$ 428.05
29	$ 275.30	$ 282.18	$ 429.91	$ 440.66
30	$ 279.23	$ 286.21	$ 436.06	$ 446.96
31	$ 285.14	$ 292.27	$ 445.28	$ 456.41
32	$ 291.04	$ 298.32	$ 454.50	$ 465.86
33	$ 294.73	$ 302.10	$ 460.26	$ 471.77
34	$ 298.67	$ 306.14	$ 466.41	$ 478.07
35	$ 300.64	$ 308.16	$ 469.48	$ 481.22
36	$ 302.60	$ 310.17	$ 472.55	$ 484.36
37	$ 304.57	$ 312.18	$ 475.63	$ 487.52
38	$ 306.54	$ 314.20	$ 478.70	$ 490.67
39	$ 310.48	$ 318.24	$ 484.85	$ 496.97
40	$ 314.41	$ 345.85	$ 490.99	$ 540.09
41	$ 320.32	$ 353.95	$ 500.22	$ 552.74
42	$ 325.98	$ 362.49	$ 509.05	$ 566.06
43	$ 333.85	$ 374.25	$ 521.35	$ 584.43
44	$ 343.69	$ 389.06	$ 536.71	$ 607.56
45	$ 355.25	$ 406.76	$ 554.77	$ 635.21
46	$ 369.03	$ 428.07	$ 576.29	$ 668.50
47	$ 384.53	$ 452.59	$ 600.49	$ 706.78
48	$ 402.24	$ 481.08	$ 628.15	$ 751.27
49	$ 419.71	$ 510.79	$ 655.43	$ 797.66
50	$ 439.39	$ 538.25	$ 686.16	$ 840.55
51	$ 458.83	$ 562.07	$ 716.51	$ 877.72
52	$ 480.23	$ 588.28	$ 749.94	$ 918.68
53	$ 501.88	$ 614.80	$ 783.75	$ 960.09
54	$ 525.25	$ 643.43	$ 820.25	$ 1,004.81
55	$ 548.62	$ 672.06	$ 856.74	$ 1,049.51
56	$ 573.96	$ 703.10	$ 896.32	$ 1,097.99
57	$ 599.55	$ 734.45	$ 936.27	$ 1,146.93
58	$ 626.86	$ 767.90	$ 978.92	$ 1,199.18
59	$ 640.39	$ 784.48	$ 1,000.05	$ 1,225.06
60	$ 667.70	$ 817.93	$ 1,042.69	$ 1,277.30
61	$ 691.32	$ 846.87	$ 1,079.57	$ 1,322.47
62	$ 706.82	$ 865.85	$ 1,103.78	$ 1,352.13
63	$ 726.25	$ 889.66	$ 1,134.13	$ 1,389.31
64+	$ 738.06	$ 904.12	$ 1,152.57	$ 1,411.90

YOUR HEALTH INSURANCE GLOSSARY

Here are some commonly used health insurance plan terms to help you.

BlueCard – A national program that enables Blue Plan members to obtain health care services while traveling or living in another Blue Plan's service area. The program links participating health care providers with independent Blue Plans across the country and in more than 200 countries and territories worldwide. The level of BlueCard access is dependent upon your plan's details. Refer to your plan documents for additional information.

Coinsurance – The costs of your care are shared between you and the insurance company. Coinsurance is the part of your medical bill that you pay after reaching your deductible. So if your medical bill for covered, in-network services is $100 and your coinsurance is 20%, you pay $20. The insurance company pays $80.

Copay or Copayment – A fixed dollar amount (like $25) that you pay each time you receive certain covered health care services.

Deductible – The amount of money you must pay for health care services before your health plan starts to pay.

- An **embedded deductible** has two parts: an individual deductible and a family deductible. Each family member can meet but not exceed his/her own deductible before the family deductible is met. (Individual deductibles add up to meet the family deductible.)

Emergency Medical Condition – An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Room Care – Emergency services you receive in an emergency room.

Emergency Services – Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

EPO (Exclusive Provider Organization) – A health plan that provides benefits when care is received from network providers. Out-of-network care is not covered (except in an emergency).

Formulary – A list of prescription drugs covered by your health plan. In a tiered drug formulary, drugs are assigned a level or tier. Each tier has a different copay or coinsurance. You usually pay less when your doctor prescribes drugs in the lower tiers.

Habilitative Services – Health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

High Deductible Health Plan (HDHP) – These plans have higher deductibles than traditional health plans. Qualified HDHPs may be combined with a health savings account (HSA) that you can fund with tax-deductible contributions up to annual limits published by the IRS. You can use the HSA to pay for unreimbursed "qualified" medical expenses. Please note that not all HDHP plans are Qualified HDHPs.

HMO (Health Maintenance Organization) – This type of health plan usually covers care only from providers who contract with the HMO. Out-of-network care is not covered (except in an emergency).

In-Network/Network Providers – A doctor, hospital, or other provider in the plan's network. In-network providers have agreed to accept a certain rate for people with that plan. You pay less when you use an in-network provider instead of an out-of-network provider. (In certain circumstances, a plan may have a contract with an out-of-network provider.)

Out-of-Area Provider – A doctor, hospital, or other provider outside your plan's service area.

Out-of-Network Provider – A doctor, hospital, or other provider who does not have a contract with your health insurer to provide services to you at a discount. You will generally pay more to see an out-of-network provider.

Out-of-Pocket Costs – The copayments, coinsurance, and deductible amounts you have to pay.

Out-of-Pocket Maximum – The most you have to pay out of your own pocket each benefit period (usually one year). After that, your health insurance company pays 100% of the cost for covered services.

PPO (Preferred Provider Organization) – In this type of health plan, you pay less if you use providers in the plan's network. You can also use providers outside of the plan's network, but will generally have higher out-of-pocket costs.

Premium – The amount of money you pay each month for your health insurance. You must pay this amount every month — even if you don't use services that month.

Preventive Care Services – Routine health care, like screenings, well visits, and checkups — to help prevent illnesses, disease, or other health problems.

Primary Care Provider (PCP) – The doctor or medical professional who provides most of your basic care, such as yearly preventive visits and screenings. In most cases, your PCP will coordinate your care with specialists, health care facilities, and other providers.

Qualified Health Plan (QHP) – An insurance plan certified by the Marketplace. It must provide the 10 essential health benefits, follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements.

Rehabilitative Services – Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Retail Clinic – Convenient walk-in centers for quick and less complex health needs that can be served outside the doctor's office. Generally opened in the evenings and on the weekends. Services include treatment of uncomplicated illness or preventive care.

Telemedicine/Virtual Medicine – Contacting and receiving health care guidance from a doctor in real time by using a smartphone, tablet, or computer.

Urgent Care Center – A walk-in center that you can use when your doctor is unavailable, such as in the evenings or on the weekends, or when you have an illness or injury serious enough that you need care right away, but not serious enough for a trip to the emergency room. Urgent care visits are usually less costly than going to the emergency room, but more costly than a PCP visit.

HIGHMARK DISCLOSURES

Important Benefit Details

1 my Direct Blue Conemaugh EPO Silver 4450 HSA Off Exchange Base, my Direct Blue EPO Silver 4450 HSA Off Exchange Base, my Direct Blue HMO Silver 4450 HSA Off Exchange Base,my Direct Blue Erie HMO Silver 4450 HSA Off Exchange Base, my Direct Blue Conemaugh EPO Extra Savings Silver 2550 On Exchange ENH 1 200-250 FPL, my Direct Blue Conemaugh EPO Extra Savings Silver 600 On Exchange ENH 2 150-200 FPL, my Direct Blue Conemaugh EPO Extra Savings Silver 100 On Exchange ENH 3 100-150 FPL, my Direct Blue HMO Extra Savings Silver 2550 On Exchange ENH 1 200-250 FPL,my Direct Blue HMO Extra Savings Silver 600 On Exchange ENH 2 150-200 FPL, my Direct Blue HMO Extra Savings Silver 100 On Exchange ENH 3 100-150 FPL, my Direct Blue Erie HMO Extra Savings Silver 2550 On Exchange ENH 1 200-250 FPL, my Direct Blue Erie HMO Extra Savings Silver 600 On Exchange ENH 2 150-200 FPL, my Direct Blue Erie HMO Extra Savings Silver 100 On Exchange ENH 3 100-150 FPL are Embedded Family Deductible: 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, 2019 – December 31, 2019), 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. No individual Member may satisfy the entire family Deductible.

2 Aggregate Family Deductible: 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, 2019– December 31, 2019), 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.

3 You are responsible for out-of-pocket costs each benefit period (January 1, 2019 – December 31, 2019) up to the maximum amount shown. Thereafter, the plan pays 100% of the Provider's Allowable Charge during the remainder of the benefit period. This amount does not include amounts in excess of the provider's allowable charge.

4 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.

5 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.

6 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.

7 Pediatric vision benefits utilize the Davis National Network. Pediatric dental benefits utilize United Concordia's Advantage Network.

8 Essential Formulary prescription drug cost covers a 90-day (Mail Order) or 31-day (Retail) supply. This plan has a four-tier closed formulary prescription drug structure.

9 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 Health Insurance Marketplace are not intended to be used with an HSA. If you have questions, please check with your financial advisor.

10 BlueCard coverage is available only for emergency or urgent care when you are away from home. Routine care is not covered. If you seek care out of your plan's service area for a non-emergent or non-urgent condition, you are responsible for all costs associated with that care.

Highmark Blue Cross Blue Shield, Highmark Choice Company, and Highmark Health Insurance Company are Qualified Health Plan issuers in the Health Insurance Marketplace.

Insurance may be provided or administered by Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Choice Company which are independent licensees of the Blue Cross and Blue Shield Association.

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, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-329-0690 (TTY/TDD 711).

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

Davis Vision is a separate company that administers the Plan's vision benefits. United Concordia is a separate company that administers the Plan's pediatric dental benefits.

You should confirm the network status of a provider prior to receiving services. You can call My Care Navigator at 1-888-BLUE-428 to confirm if a doctor or facility will be in network in 2019.

Blues On Call is a registered service mark of the Blue Cross and Blue Shield Association.

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 for Civil Rights Complaint Portal, available at 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
1-800-368-1019, 800-537-7697 (TDD)

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

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。
請致電 1-800-876-7639.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.
1-800-876-7639 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-800-876-7639 .

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-800-876-7639 .

BE CONFIDENT in your choice of health plan.

Complete the checklist below to make sure you've answered the most important questions before choosing a plan.

- [ ] I have reviewed the hospitals that will be in-network and out-of-network for my plan.
- [ ] I've checked to see if my doctor is in-network by calling **1-888-BLUE-428** or visiting MyCareNavigator.com OR **Find a Doctor or Rx** at HighmarkBCBS.com.
- [ ] I understand that my plan covers emergency and out-of-area urgent care.
- [ ] I have checked how my prescription drugs are covered at HighmarkEssentialFormulary.com.

There's a lot to know and do when it comes to picking the right plan for you and your family. We are here to help!

- Call us at **1-855-822-6927** (TTY/TDD 711)
- Visit your Highmark health insurance store
- Visit DiscoverHighmark.com
- Talk to your local insurance agent

You can also visit the Health Insurance Marketplace ("the Marketplace") at HealthCare.gov, or call the Marketplace at **1-800-318-2596** (TTY: 1-855-889-4325).

HIGHMARK

WPA-27611 1/19 HC403531