HIGHMARK. Delaware

All for Health.


# 2017 Health Insurance

Benefit Period January 1, 2017 to December 31, 2017

# Now's the time to choose new health insurance, and we want to help you find what's best for you.

At Highmark Blue Cross Blue Shield Delaware (Highmark Delaware), we believe that you should have a better health care experience, and that starts by putting you first. How do we do that? By giving you the peace of mind that comes from knowing you have reliable coverage that gives you access to more than 93% of physicians and more than 96% of hospitals across the country.*

This step-by-step guide to enrollment will help you understand Highmark Delaware health plans, explore your options and choose what's right for you. It's part of our commitment to you to make great health care simple and accessible.

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

- Call **1-855-329-0694** (TTY/TDD 711)
- Visit **DiscoverHighmark.com**
- Your insurance agent

**We can also help you enroll through the Health Insurance Marketplace.**

**Or you can contact the Marketplace at:**

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

## Getting Covered is as Quick as 1, 2, 3:



*Blue Cross Blue Shield Association, National Access (2016). Retrieved from http://www.bcbs.com/healthcare-news/press-center/blue-facts.html 9-13-16

# Step 1

# Know Your Dates

Open Enrollment is the period of time when you can enroll in health insurance or switch to something different. Enroll by December 15, 2016 for January 1st coverage — so you won't have a lapse in coverage.

**If you don't enroll in a health insurance plan for 2017, you may be charged a fee by the federal government, which can be very costly. To avoid this fee and a lapse in coverage, sign up for a 2017 health insurance plan during Open Enrollment.**

## 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
- Moving to a new, permanent residence where you can't have access to different health plans
- Losing minimum essential coverage

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 that verify your eligibility.

# Step 2

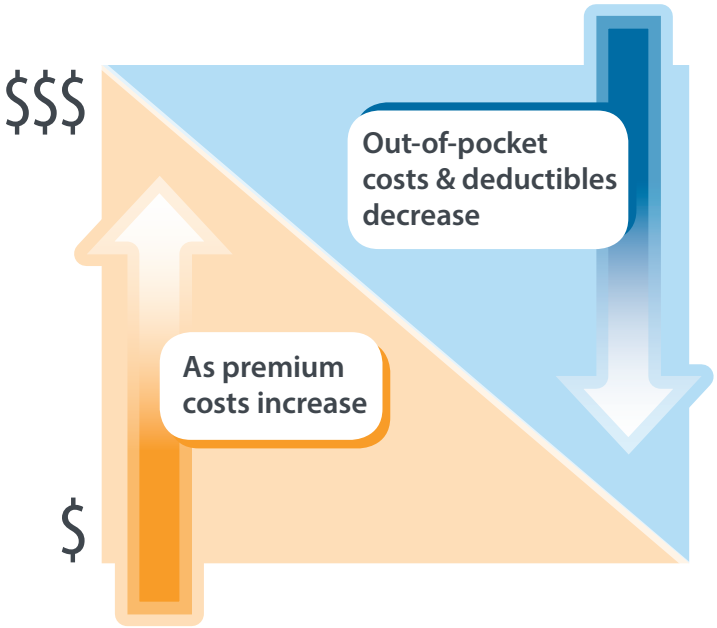
# What's New, What Stays the Same

There will be some plan changes in 2017. Although the exact coverage you have today may not be available in 2017, Highmark Delaware may still have a plan to meet your needs.

## What's New

### Highmark Delaware Plan Options

Highmark Delaware has many Exclusive Provider Organization (EPO) plan options including high deductible health plans and plans with copays for common medical services before deductible. All of our EPO plans include the Affordable Care Act essential health benefits and provide coverage when using a network provider (or in the case of an emergency).




**Health Savings Embedded Blue EPO** and **Health Savings Blue EPO** plans are qualified high-deductible health plans that offer the tax and savings advantages of a Health Savings Account (HSA). You pay all costs until your deductible is met. After that, your health insurance company pays most of the plan allowance for covered in-network care for the remainder of the benefit period. See **Glossary on page 17** for more information on Embedded vs Non-Embedded plans. Plans available in Bronze, Silver and Gold.

**Please note:** 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.

The **Total Health Flex Blue EPO** plan is a more personalized care approach to your health. It helps you coordinate all health care needs for a medical condition (e.g. diabetes, heart disease, etc.) through a primary care doctor. You will pay lower costs on generic drugs and visits to certain primary care doctors who take part in this program. This plan is only offered at the Silver metal level.

To select a Total Health Flex Blue provider, please look for the Blue Distinction Total Care symbol in our **Find A Doctor** physician directory.

Blue Distinction® Total Care

**Shared Cost Blue EPO** plans have copays with coverage for some services right from the start. For other services, you need to meet your deductible before we pay for your care. These plans have a wide range of deductibles. Plans available in Bronze, Silver and Gold.

The **Major Events Blue EPO** plan provides basic coverage if you are under 30 or meet financial hardship requirements. You get the protection you need in case of an emergency and your first 3 visits to your primary care doctor are covered at no cost. (Contact the Health Insurance Marketplace to determine financial hardship eligibility.)

## Find a Doctor

Find a Doctor makes it simple to find in-network doctors and hospitals wherever you live or travel. Check to see if your doctor and hospital are in the network of the plan you are considering by visiting Find a Doctor at **highmarkbcbsde.com/find-a-doctor.**

# What Stays the Same

## Prescription Drugs

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

When talking with your doctor about prescription drugs, ask if you can take a generic version instead of a brand name drug. Generic drugs usually work just as well for most people, and may cost less.

Highmark Delaware plans offer the HCR Comprehensive formulary, which has:

- An open formulary, meaning that the plan will pay for formulary and non-formulary drugs
- Generics and brands that are on different levels. You can save money when your doctor prescribes drugs on the lowest level

| | |
|---|---|
| **Low-Cost Generic*** | $ (least costly) |
| **Generic** | $$ |
| **Brand Formulary & Non-Formulary** | $$$ (most costly) |

*Only available with Total Health Flex Blue EPO plan

## Specialty Pharmacy

Specialty drugs are for complex, chronic conditions, such as multiple sclerosis or cancer and are available in the Highmark Delaware formulary. To ensure your safety, we only allow approved specialty pharmacies to deliver these drugs.

# Telemedicine

**Sudden sickness can disrupt work, school and family activities. When you want reassurance and symptom relief for minor health issues but can't wait for an appointment, telemedicine can be the answer. Highmark Delaware provides you access to doctors who help you over the phone or Internet-based video. Telemedicine is convenient, quality health care, when and where you need it.**

# Mail Order Prescription Drugs

**Highmark Delaware's mail order pharmacy may be able to help you save money on your maintenance medications — the prescriptions you take regularly (usually every day). With mail order, you can get a 90-day supply conveniently sent by mail to your home in safe, secure packaging.**

## Metal Levels & Essential Health Benefits

When shopping for a health insurance plan, it's important that you know about the metal levels and essential health benefits.

## Metal Levels

Affordable Care Act (ACA) health plans are grouped in four metal categories: Bronze, Silver, Gold, and Platinum. The levels are based on how you and your health plan split the costs of your health care. They have nothing to do with the quality of care you receive.

## Essential Health Benefits

Highmark Delaware 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

**2017 Highmark Delaware health plans are available on pages 8-15 for you to review. For more information on terms, please look at Your Health Care Glossary on page 17.**

# Step 3

# How to Enroll

## Do You Qualify for Financial Help?

Most people who buy insurance through the Health Insurance Marketplace qualify for financial help. Before you enroll, you should determine if you can get financial help to lower the cost of your monthly premium and/or lower your out-of-pocket costs. To see if you may be eligible, check the **2017 Household Income Chart** below.

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

- **Advanced Premium Tax Credits (APTC)** may be applied (in advance) to lower what you pay each month (the 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 doctors' visits, lab tests, drugs and other covered services. You can only get these savings if you enroll in a Marketplace Silver metal-level plan.

### You Will Need Important Enrollment & Financial Help Documents

**Gather these documents** to see if you're eligible for financial help. You will also need these to complete enrollment 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

## 2017 Household Income Chart

| | Persons in family/household | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| **APTC** | $11,880 - $47,520 | $16,020 - $64,080 | $20,160 - $80,640 | $24,300 - $97,200 | $28,440 - $113,760 | $32,580 - $130,320 | $36,730 - $146,920 | $40,890 - $163,560 |
| **CSR*** | $11,880 - $29,700 | $16,020 - $40,050 | $20,160 - $50,400 | $24,300 - $60,750 | $28,440 - $71,100 | $32,580 - $81,450 | $36,730 - $91,825 | $40,890 - $102,225 |

Eligibility for financial help can only be determined by requesting eligibility verification through the Health Insurance Marketplace at HealthCare.gov. This is only applicable for coverage in 2017 and in the 48 contiguous states and the District of Columbia. American Indians and Alaska Natives who are members of federally recognized tribes are eligible for cost-sharing reductions at alternative dollar thresholds. For families/households with more than 8 persons, add $4,160 for each additional person.

HHS Poverty Guidelines for 2016 (January 25, 2016). Retrieved from https://aspe.hhs.gov/computations-2016-poverty-guidelines 7-26-16

*American Indian and Alaska Native cost-sharing reductions apply to individual plans at any metal level through the Marketplace.

# Understanding Your Monthly Premium Rates

Review your base monthly premium rates for each plan on page 20 of this brochure. The base premium rate listed is the maximum amount an individual* will pay every month. Find by:

- The Highmark Delaware plan you wish to purchase
- Your age (and the age of each dependent)
- Your tobacco use (and the tobacco use of each dependent)

## For families with more than three children under age 21:

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

**Remember, you may save on monthly premiums if you qualify for financial help and purchase a plan through the Health Insurance Marketplace. Highmark Delaware offers plans on the Marketplace and can help check your eligibility for financial help.**

## Checklist for Easier Enrollment

- **Review and compare** the 2017 Highmark Delaware health plans that are available as listed on the following pages. Please note that the Major Events (Catastrophic) plan is only for individuals and their families under age 30 or those who meet financial hardship requirements.
- **Review all of your plan options**, which may include health plans available on the Health Insurance Marketplace. Using the **Base Plan ID** — top left corner — for each of the following Highmark Delaware plan pages will help you find us on the Marketplace.
- **Make sure that you have all of your documents** to see if you are eligible for financial help and to have an easier enrollment process.
- **Review your monthly base premium rate** listed in this brochure for the plan(s) you are considering to enroll in. Remember, this rate may change if you receive financial help.

If you are looking for additional plan details, each plan's Summary of Benefits and Coverage is available online at **HighmarkBCBSDE-SBC.com**.

If you do not have online access, you can get a paper copy of any Summary of Benefits free of charge by calling toll-free **1-855-329-0694** (TTY/TDD 711).

*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.

# Total Health Flex Blue EPO 3000

Base Plan ID: 76168DE0640003-01

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

## Silver

| | Plan Benefits |
|---|---|
| **Deductible (Individual)** | $3,000 |
| **Deductible (Family)[1]** | $6,000 |
| **Out-of-Pocket Maximum (Individual)[3]** | $7,150 |
| **Out-of-Pocket Maximum (Family) [3]** | $14,300 |
| **Coinsurance** | 20% after deductible |
| **Primary Care Physician Office Visit** | $40 copay (BDTC) / $60 copay (Non-BDTC)* |
| **Specialist Office Visit** | $90 copay |
| **Urgent Care Office Visit** | $110 copay |
| **Emergency Room Visit** | $450 copay |
| **Ambulance** | 20% after deductible |
| **Inpatient Hospital** | 20% after deductible |
| **Outpatient Surgery** | 20% after deductible |
| **Maternity Services** | 20% after deductible |
| **Diagnostic Lab[4]** | $90 copay |
| **Diagnostic X-Ray & Advanced Imaging[5, 6]** | Diagnostic X-ray: $90 copay / Advanced Imaging: $350 copay |
| **Therapy and Rehab Services (Rehabilitative & Habilitative)[7]** | $90 copay |
| **Chiropractor Services[8]** | 20% after deductible |
| **Skilled Nursing Facility Care [9]** | 20% after deductible |
| **Inpatient Mental Health** | 20% after deductible |
| **Outpatient Mental Health** | $90 copay |
| **Inpatient Substance Abuse Rehab** | 20% after deductible |
| **Inpatient Substance Abuse Detox** | 20% after deductible |
| **Outpatient Substance Abuse** | $90 copay |
| **Adult Routine Vision Exam[10, 11]** | 0% |
| **Pediatric Vision Services[10, 11]** | Exam: 0%; Frames/Lenses: 0% |
| **Pediatric Dental Services[11]** | Exam/Cleaning: 0%; All other benefits: 50% |

| Prescription Formulary | HCR Comprehensive Formulary[12] | | |
|---|---|---|---|
| | Low-Cost Generic | Standard Generic | Brand Formulary & Non-Formulary |
| **Retail Pharmacy or Mail Order (34-90 day supply)** | $3 Copay | $10 Copay | 20% no deductible |

*Blue Distinction Total Care (BDTC) – To select a Total Health Flex Blue provider, please look for the "Blue Distinction Total Care" symbol in our Find A Doctor physician directory at highmarkbcbsde.com/find-a-doctor.

# Shared Cost Blue EPO 1000

Base Plan ID: 76168DE0410012-01

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

## Gold

| | Plan Benefits |
|---|---|
| **Deductible (Individual)** | $1,000 |
| **Deductible (Family)**[1] | $2,000 |
| **Out-of-Pocket Maximum (Individual)**[3] | $6,000 |
| **Out-of-Pocket Maximum (Family)** [3] | $12,000 |
| **Coinsurance** | 20% after deductible |
| **Primary Care Physician Office Visit** | $35 copay |
| **Specialist Office Visit** | $45 copay |
| **Urgent Care Office Visit** | $65 copay |
| **Emergency Room Visit** | $350 copay |
| **Ambulance** | 20% after deductible |
| **Inpatient Hospital** | 20% after deductible |
| **Outpatient Surgery** | 20% after deductible |
| **Maternity Services** | 20% after deductible |
| **Diagnostic Lab**[4] | $25 copay |
| **Diagnostic X-Ray & Advanced Imaging**[5, 6] | 20% after deductible |
| **Therapy and Rehab Services (Rehabilitative & Habilitative)**[7] | 20% after deductible |
| **Chiropractor Services**[8] | 20% after deductible |
| **Skilled Nursing Facility Care**[9] | 20% after deductible |
| **Inpatient Mental Health** | 20% after deductible |
| **Outpatient Mental Health** | $45 copay |
| **Inpatient Substance Abuse Rehab** | 20% after deductible |
| **Inpatient Substance Abuse Detox** | 20% after deductible |
| **Outpatient Substance Abuse** | $45 copay |
| **Adult Routine Vision Exam**[10, 11] | 0% |
| **Pediatric Vision Services**[10, 11] | Exam: 0%; Frames/Lenses: 0% |
| **Pediatric Dental Services**[11] | Exam/Cleaning: 0%; All other benefits: 50% |

| Prescription Drugs | HCR Comprehensive Formulary[12] | |
|---|---|---|
| | Generic | Brand Formulary & Non-Formulary |
| **Retail Pharmacy or Mail Order (34-90 day supply)** | $15 copay | 20% no deductible |

# Shared Cost Blue EPO 4200

Base Plan ID: 76168DE0410013-01

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

**Silver**

| | Plan Benefits |
|---|---|
| **Deductible (Individual)** | $4,200 |
| **Deductible (Family)[1]** | $8,400 |
| **Out-of-Pocket Maximum (Individual)[3]** | $7,150 |
| **Out-of-Pocket Maximum (Family) [3]** | $14,300 |
| **Coinsurance** | 20% after deductible |
| **Primary Care Physician Office Visit** | $30 copay |
| **Specialist Office Visit** | 20% after deductible |
| **Urgent Care Office Visit** | $75 copay |
| **Emergency Room Visit** | $350 copay |
| **Ambulance** | 20% after deductible |
| **Inpatient Hospital** | 20% after deductible |
| **Outpatient Surgery** | 20% after deductible |
| **Maternity Services** | 20% after deductible |
| **Diagnostic Lab[4]** | $30 copay |
| **Diagnostic X-Ray & Advanced Imaging[5, 6]** | 20% after deductible |
| **Therapy and Rehab Services (Rehabilitative & Habilitative)[7]** | 20% after deductible |
| **Chiropractor Services[8]** | 20% after deductible |
| **Skilled Nursing Facility Care [9]** | 20% after deductible |
| **Inpatient Mental Health** | 20% after deductible |
| **Outpatient Mental Health** | 20% after deductible |
| **Inpatient Substance Abuse Rehab** | 20% after deductible |
| **Inpatient Substance Abuse Detox** | 20% after deductible |
| **Outpatient Substance Abuse** | 20% after deductible |
| **Adult Routine Vision Exam[10, 11]** | 0% |
| **Pediatric Vision Services[10, 11]** | Exam: 0%; Frames/Lenses: 0% |
| **Pediatric Dental Services[11]** | Exam/Cleaning: 0%; All other benefits: 50% |

| Prescription Drugs | HCR Comprehensive Formulary[12] | |
|---|---|---|
| | Generic | Brand Formulary & Non-Formulary |
| **Retail Pharmacy or Mail Order (34-90 day supply)** | $15 copay | 20% no deductible |

# Shared Cost Blue EPO 6800

Base Plan ID: 76168DE0410010-01

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

## Bronze

| | Plan Benefits |
|---|---|
| **Deductible (Individual)** | $6,800 |
| **Deductible (Family)[1]** | $13,600 |
| **Out-of-Pocket Maximum (Individual)[3]** | $7,150 |
| **Out-of-Pocket Maximum (Family) [3]** | $14,300 |
| **Coinsurance** | 10% after deductible |
| **Primary Care Physician Office Visit** | $25 copay |
| **Specialist Office Visit** | 10% after deductible |
| **Urgent Care Office Visit** | 10% after deductible |
| **Emergency Room Visit** | 10% after deductible |
| **Ambulance** | 10% after deductible |
| **Inpatient Hospital** | 10% after deductible |
| **Outpatient Surgery** | 10% after deductible |
| **Maternity Services** | 10% after deductible |
| **Diagnostic Lab[4]** | $50 copay |
| **Diagnostic X-Ray & Advanced Imaging[5, 6]** | 10% after deductible |
| **Therapy and Rehab Services (Rehabilitative & Habilitative)[7]** | 10% after deductible |
| **Chiropractor Services[8]** | 10% after deductible |
| **Skilled Nursing Facility Care [9]** | 10% after deductible |
| **Inpatient Mental Health** | 10% after deductible |
| **Outpatient Mental Health** | 10% after deductible |
| **Inpatient Substance Abuse Rehab** | 10% after deductible |
| **Inpatient Substance Abuse Detox** | 10% after deductible |
| **Outpatient Substance Abuse** | 10% after deductible |
| **Adult Routine Vision Exam[10, 11]** | 0% |
| **Pediatric Vision Services[10, 11]** | Exam: 0%; Frames/Lenses: 0% |
| **Pediatric Dental Services[11]** | Exam/Cleaning: 0%; All other benefits: 50% |

| Prescription Drugs | HCR Comprehensive Formulary[12] | |
|---|---|---|
| | Generic | Brand Formulary & Non-Formulary |
| **Retail Pharmacy or Mail Order (34-90 day supply)** | 50% after deductible | 50% after deductible |

# Health Savings Blue EPO 1700

Base Plan ID: 76168DE0650001-01

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

## Gold

| | Plan Benefits |
|---|---|
| **Deductible (Individual)** | $1,700 |
| **Deductible (Family)[2]** | $3,400 |
| **Out-of-Pocket Maximum (Individual)[3]** | $3,250 |
| **Out-of-Pocket Maximum (Family) [3]** | $6,500 |
| **Coinsurance** | 10% after deductible |
| **Primary Care Physician Office Visit** | 10% after deductible |
| **Specialist Office Visit** | 10% after deductible |
| **Urgent Care Office Visit** | 10% after deductible |
| **Emergency Room Visit** | 10% after deductible |
| **Ambulance** | 10% after deductible |
| **Inpatient Hospital** | 10% after deductible |
| **Outpatient Surgery** | 10% after deductible |
| **Maternity Services** | 10% after deductible |
| **Diagnostic Lab[4]** | 10% after deductible |
| **Diagnostic X-Ray & Advanced Imaging[5, 6]** | 10% after deductible |
| **Therapy and Rehab Services (Rehabilitative & Habilitative)[7]** | 10% after deductible |
| **Chiropractor Services[8]** | 10% after deductible |
| **Skilled Nursing Facility Care [9]** | 10% after deductible |
| **Inpatient Mental Health** | 10% after deductible |
| **Outpatient Mental Health** | 10% after deductible |
| **Inpatient Substance Abuse Rehab** | 10% after deductible |
| **Inpatient Substance Abuse Detox** | 10% after deductible |
| **Outpatient Substance Abuse** | 10% after deductible |
| **Adult Routine Vision Exam[10, 11]** | 0% |
| **Pediatric Vision Services[10, 11]** | Exam: 0%; Frames/Lenses: 0% |
| **Pediatric Dental Services[11]** | Exam/Cleaning: 0%; All other benefits: 10% after deductible |

| Prescription Drugs | HCR Comprehensive Formulary[12] | |
|---|---|---|
| | Generic | Brand Formulary & Non-Formulary |
| **Retail Pharmacy or Mail Order (34-90 day supply)** | 10% after deductible | 10% after deductible |

# Health Savings Embedded Blue EPO 3250

Base Plan ID: 76168DE0480001-01

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

**Silver**

| | Plan Benefits |
|---|---|
| **Deductible (Individual)** | $3,250 |
| **Deductible (Family)[1]** | $6,500 |
| **Out-of-Pocket Maximum (Individual)[3]** | $6,500 |
| **Out-of-Pocket Maximum (Family) [3]** | $13,000 |
| **Coinsurance** | 10% after deductible |
| **Primary Care Physician Office Visit** | 10% after deductible |
| **Specialist Office Visit** | 10% after deductible |
| **Urgent Care Office Visit** | 10% after deductible |
| **Emergency Room Visit** | 10% after deductible |
| **Ambulance** | 10% after deductible |
| **Inpatient Hospital** | 10% after deductible |
| **Outpatient Surgery** | 10% after deductible |
| **Maternity Services** | 10% after deductible |
| **Diagnostic Lab[4]** | 10% after deductible |
| **Diagnostic X-Ray & Advanced Imaging[5, 6]** | 10% after deductible |
| **Therapy and Rehab Services (Rehabilitative & Habilitative)[7]** | 10% after deductible |
| **Chiropractor Services[8]** | 10% after deductible |
| **Skilled Nursing Facility Care [9]** | 10% after deductible |
| **Inpatient Mental Health** | 10% after deductible |
| **Outpatient Mental Health** | 10% after deductible |
| **Inpatient Substance Abuse Rehab** | 10% after deductible |
| **Inpatient Substance Abuse Detox** | 10% after deductible |
| **Outpatient Substance Abuse** | 10% after deductible |
| **Adult Routine Vision Exam[10, 11]** | 0% |
| **Pediatric Vision Services[10, 11]** | Exam: 0%; Frames/Lenses: 0% |
| **Pediatric Dental Services[11]** | Exam/Cleaning: 0%; All other benefits: 10% after deductible |

| Prescription Drugs | HCR Comprehensive Formulary[12] | |
|---|---|---|
| | Generic | Brand Formulary & Non-Formulary |
| **Retail Pharmacy or Mail Order (34-90 day supply)** | 10% after deductible | 10% after deductible |

# Health Savings Embedded Blue EPO 6500

Base Plan ID: 76168DE0420001-01

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

## Bronze

| | Plan Benefits |
|---|---|
| **Deductible (Individual)** | $6,500 |
| **Deductible (Family)[1]** | $13,000 |
| **Out-of-Pocket Maximum (Individual)[3]** | $6,500 |
| **Out-of-Pocket Maximum (Family) [3]** | $13,000 |
| **Coinsurance** | 0% after deductible |
| **Primary Care Physician Office Visit** | 0% after deductible |
| **Specialist Office Visit** | 0% after deductible |
| **Urgent Care Office Visit** | 0% after deductible |
| **Emergency Room Visit** | 0% after deductible |
| **Ambulance** | 0% after deductible |
| **Inpatient Hospital** | 0% after deductible |
| **Outpatient Surgery** | 0% after deductible |
| **Maternity Services** | 0% after deductible |
| **Diagnostic Lab[4]** | 0% after deductible |
| **Diagnostic X-Ray & Advanced Imaging[5, 6]** | 0% after deductible |
| **Therapy and Rehab Services (Rehabilitative & Habilitative)[7]** | 0% after deductible |
| **Chiropractor Services[8]** | 0% after deductible |
| **Skilled Nursing Facility Care [9]** | 0% after deductible |
| **Inpatient Mental Health** | 0% after deductible |
| **Outpatient Mental Health** | 0% after deductible |
| **Inpatient Substance Abuse Rehab** | 0% after deductible |
| **Inpatient Substance Abuse Detox** | 0% after deductible |
| **Outpatient Substance Abuse** | 0% after deductible |
| **Adult Routine Vision Exam[10, 11]** | 0% |
| **Pediatric Vision Services[10, 11]** | Exam: 0%; Frames/Lenses: 0% |
| **Pediatric Dental Services[11]** | Exam/Cleaning: 0%; All other benefits: 0% after deductible |

| Prescription Drugs | HCR Comprehensive Formulary[12] | |
|---|---|---|
| | Generic | Brand Formulary & Non-Formulary |
| **Retail Pharmacy or Mail Order (34-90 day supply)** | 0% after deductible | 0% after deductible |

# Major Events Blue EPO 7150

Base Plan ID: 76168DE0400001-01

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

## Catastrophic

| | Plan Benefits |
|---|---|
| **Deductible (Individual)** | $7,150 |
| **Deductible (Family)**[1] | $14,300 |
| **Out-of-Pocket Maximum (Individual)**[3] | $7,150 |
| **Out-of-Pocket Maximum (Family)** [3] | $14,300 |
| **Coinsurance** | 0% after deductible |
| **Primary Care Physician Office Visit** | 0% after deductible - Eligible for 3 PCP visits per benefit period prior to deductible at no cost |
| **Specialist Office Visit** | 0% after deductible |
| **Urgent Care Office Visit** | 0% after deductible |
| **Emergency Room Visit** | 0% after deductible |
| **Ambulance** | 0% after deductible |
| **Inpatient Hospital** | 0% after deductible |
| **Outpatient Surgery** | 0% after deductible |
| **Maternity Services** | 0% after deductible |
| **Diagnostic Lab**[4] | 0% after deductible |
| **Diagnostic X-Ray & Advanced Imaging**[5, 6] | 0% after deductible |
| **Therapy and Rehab Services (Rehabilitative & Habilitative)**[7] | 0% after deductible |
| **Chiropractor Services**[8] | 0% after deductible |
| **Skilled Nursing Facility Care**[9] | 0% after deductible |
| **Inpatient Mental Health** | 0% after deductible |
| **Outpatient Mental Health** | 0% after deductible |
| **Inpatient Substance Abuse Rehab** | 0% after deductible |
| **Inpatient Substance Abuse Detox** | 0% after deductible |
| **Outpatient Substance Abuse** | 0% after deductible |
| **Adult Routine Vision Exam**[10, 11] | 0% after deductible |
| **Pediatric Vision Services**[10, 11] | 0% after deductible |
| **Pediatric Dental Services**[11] | 0% after deductible |

| Prescription Drugs | HCR Comprehensive Formulary[12] | |
|---|---|---|
| | Generic | Brand Formulary & Non-Formulary |
| **Retail Pharmacy or Mail Order (34-90 day supply)** | 0% after deductible | 0% after deductible |

# Highmark Blue Cross Blue Shield Delaware Disclosures

## Important Benefit Details

[1] **Health Savings Embedded Blue EPO 3250, Health Savings Embedded Blue EPO 6500, Shared Cost Blue EPO 1000, Shared Cost Blue EPO 4200, Shared Cost Blue EPO 6800, Total Health Flex Blue EPO 3000, Major Events Blue EPO 7150 plans include an Embedded/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, 2017– December 31, 2017), 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] **Health Savings Blue EPO 1700, plans include a Non-Embedded Family Deductible:** For an agreement covering more than one (1) family member, the ENTIRE family deductible must be met within a benefit period (January 1, 2017 – December 31, 2017) before Highmark will pay for covered services for ANY family member. The family deductible can be satisfied by an individual family member or a combination of one or more family members.

[3] You are responsible for out-of-pocket costs each benefit period (January 1, 2017 – December 31, 2017) 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/coinsurance 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/coinsurance 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/coinsurance per date of service and type of service.

[7] Therapy and Rehab Services (Rehabilitative & Habilitative) - Therapy visit limits include in and out-of-network visits. Speech therapy is limited to 30 visits per contract year each for Rehabilitative and Habilitative service (60 visits total per contract year). Physical therapy and occupational therapy are a combined 30 visit limit per contract year each for Rehabilitative and Habilitative service (60 visits total per contract year).

[8] Chiropractor Services - Benefit Maximum: 30 Visits per Benefit Period.

[9] Skilled Nursing Facility Care - Benefit Maximum: 120 days per confinement; benefits renew after 180 days without care.

[10] Adult & Pediatric Routine Vision Exam - Benefit Maximum: One adult exam every 24 months for members 19 and older; One pediatric exam every 12 months for members under the age of 19.

[11] Adult Routine Vision Exam & Pediatric Vision Services - Vision benefits utilize the Davis Vison-Health Care Reform Network. Pediatric Dental Benefits utilize Advantage Plus 2.0 Network.

[12] All Highmark Delaware plans provide the HCR Comprehensive Formulary on the National Plus network. Prescription drug copay/coinsurance for up to a 90-day supply (Mail & Retail): $15 generic (Shared Cost); $3/$10 generic (Total Health Flex). Mail order available.

All Highmark Delaware Health Savings base plans are Qualified High Deductible Health Plans and 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.

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Highmark Blue Cross Blue Shield Delaware is a Qualified Health Plan issuer in the Health Insurance Marketplace.

Insurance may be provided by Highmark Blue Cross Blue Shield Delaware which is an independent licensee 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 (855) 329-0694 (TTY/TDD 711).

Blue Distinction Total Care - Designation as a Blue Distinction Total Care Provider means this Provider has met the established national criteria. To find out which services are covered under your policy at any facilities, please call your local Blue Cross and/or Blue Shield Plan; and call your provider before making an appointment, to verify the most current information on its Network participation and Blue Distinction Total Care status. Neither Blue Cross and Blue Shield Association nor any of its Licensees are responsible for any damages, losses, or non-covered charges that may result from using Blue Distinction or receiving care from a Blue Distinction or other provider.

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.

# Your Health Care Glossary

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

**BlueCard® –** Wherever you go nationwide as a Highmark member, you're in the Blue network. Just show your BlueCard at the thousands of participating physicians and hospitals across the country, and you'll receive in-network access away from home.

**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. For example, 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 (for example, $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 the health plan starts to pay.

- An embedded/aggregate 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.)
- With a non-embedded family deductible, the amount of the deductible can be met by one family member or by a combination of family members. The health plan does not begin to pay for any individual medical expenses until the family deductible is met.

**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). BlueCard is available with all Highmark EPO plans.

**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.

**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.

**Network Providers –** Doctors, hospitals, clinics, labs and other providers who have a contract with a health plan to provide health services to its members. You pay less when you use network providers.

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

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

**Premium –** The amount of money you pay each month for your health insurance. You must pay this dollar 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 Physician (PCP) –** The doctor 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 Health Insurance 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.

**Urgent Care Center –** A walk-in center that you can use when your doctor is unavailable, 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 Primary Care Physician (PCP) visit.

# Committed to Providing Outstanding Service

**Discrimination is Against the Law**

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other 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 Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, 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.

If you speak English, language assistance services, free of charge, are available to you. Call 1-877-959-2563.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-877-959-2563.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-877-959-2563.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-877-959-2563.

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-877-959-2563 નંબર પર ફોન કરો.

# Committed to Providing Outstanding Service

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-877-959-2563.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-877-959-2563 로 전화.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-877-959-2563.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-877-959-2563.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-877-959-2563.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-877-959-2563.

यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। 1-877-959-2563 पर फ़ोन करें।

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ 1-877-959-2563 پر کال کریں۔

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-877-959-2563 .

మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. కాల్ చేయండి 1-877-959-2563.

Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel 1-877-959-2563.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-877-959-2563.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-877-959-2563.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-877-959-2563.

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。 1-877-959-2563 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-877-959-2563 .

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-877-959-2563.

## Kent, New Castle and Sussex

# BASE RATES FOR YOUR COUNTY

| | TOTAL HEALTH | | SHARED COST | | | | | | HEALTH SAVINGS | | | | | | MAJOR EVENTS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Silver | | Gold | | Silver | | Bronze | | Gold | | Silver | | Bronze | | Catastrophic | |
| | Total Health Flex Blue EPO 3000 | | Shared Cost Blue EPO 1000 | | Shared Cost Blue EPO 4200 | | Shared Cost Blue EPO 6800 | | Health Savings Blue EPO 1700 | | Health Savings Embedded Blue EPO 3250 | | Health Savings Embedded Blue EPO 6500 | | Major Events Blue EPO 7150 | |
| Age | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco | Non-Tobacco | Tobacco |
| 0 - 20 | $241.25 | $241.25 | $281.79 | $281.79 | $238.41 | $238.41 | $185.85 | $185.85 | $287.95 | $287.95 | $238.61 | $238.61 | $187.99 | $187.99 | $169.91 | $169.91 |
| 21 | $379.92 | $389.42 | $443.77 | $454.86 | $375.45 | $384.84 | $292.67 | $299.99 | $453.47 | $464.81 | $375.76 | $385.15 | $296.04 | $303.44 | $267.57 | $274.26 |
| 22 | $379.92 | $389.42 | $443.77 | $454.86 | $375.45 | $384.84 | $292.67 | $299.99 | $453.47 | $464.81 | $375.76 | $385.15 | $296.04 | $303.44 | $267.57 | $274.26 |
| 23 | $379.92 | $389.42 | $443.77 | $454.86 | $375.45 | $384.84 | $292.67 | $299.99 | $453.47 | $464.81 | $375.76 | $385.15 | $296.04 | $303.44 | $267.57 | $274.26 |
| 24 | $379.92 | $389.42 | $443.77 | $454.86 | $375.45 | $384.84 | $292.67 | $299.99 | $453.47 | $464.81 | $375.76 | $385.15 | $296.04 | $303.44 | $267.57 | $274.26 |
| 25 | $381.44 | $390.98 | $445.55 | $456.69 | $376.95 | $386.37 | $293.84 | $301.19 | $455.28 | $466.66 | $377.26 | $386.69 | $297.22 | $304.65 | $268.64 | $275.36 |
| 26 | $389.04 | $398.77 | $454.42 | $465.78 | $384.46 | $394.07 | $299.69 | $307.18 | $464.35 | $475.96 | $384.78 | $394.40 | $303.14 | $310.72 | $273.99 | $280.84 |
| 27 | $398.16 | $408.11 | $465.07 | $476.70 | $393.47 | $403.31 | $306.72 | $314.39 | $475.24 | $487.12 | $393.80 | $403.65 | $310.25 | $318.01 | $280.41 | $287.42 |
| 28 | $412.97 | $423.29 | $482.38 | $494.44 | $408.11 | $418.31 | $318.13 | $326.08 | $492.92 | $505.24 | $408.45 | $418.66 | $321.80 | $329.85 | $290.85 | $298.12 |
| 29 | $425.13 | $435.76 | $496.58 | $508.99 | $420.13 | $430.63 | $327.50 | $335.69 | $507.43 | $520.12 | $420.48 | $430.99 | $331.27 | $339.55 | $299.41 | $306.90 |
| 30 | $431.21 | $441.99 | $503.68 | $516.27 | $426.14 | $436.79 | $332.18 | $340.48 | $514.69 | $527.56 | $426.49 | $437.15 | $336.01 | $344.41 | $303.69 | $311.28 |
| 31 | $440.33 | $451.34 | $514.33 | $527.19 | $435.15 | $446.03 | $339.20 | $347.68 | $525.57 | $538.71 | $435.51 | $446.40 | $343.11 | $351.69 | $310.11 | $317.86 |
| 32 | $449.45 | $460.69 | $524.98 | $538.10 | $444.16 | $455.26 | $346.23 | $354.89 | $536.46 | $549.87 | $444.52 | $455.63 | $350.22 | $358.98 | $316.54 | $324.45 |
| 33 | $455.14 | $466.52 | $531.64 | $544.93 | $449.79 | $461.03 | $350.62 | $359.39 | $543.26 | $556.84 | $450.16 | $461.41 | $354.66 | $363.53 | $320.55 | $328.56 |
| 34 | $461.22 | $472.75 | $538.74 | $552.21 | $455.80 | $467.20 | $355.30 | $364.18 | $550.51 | $564.27 | $456.17 | $467.57 | $359.39 | $368.37 | $324.83 | $332.95 |
| 35 | $464.26 | $475.87 | $542.29 | $555.85 | $458.80 | $470.27 | $357.64 | $366.58 | $554.14 | $567.99 | $459.18 | $470.66 | $361.76 | $370.80 | $326.97 | $335.14 |
| 36 | $467.30 | $478.98 | $545.84 | $559.49 | $461.80 | $473.35 | $359.98 | $368.98 | $557.77 | $571.71 | $462.18 | $473.73 | $364.13 | $373.23 | $329.11 | $337.34 |
| 37 | $470.34 | $482.10 | $549.39 | $563.12 | $464.81 | $476.43 | $362.33 | $371.39 | $561.40 | $575.44 | $465.19 | $476.82 | $366.50 | $375.66 | $331.25 | $339.53 |
| 38 | $473.38 | $485.21 | $552.94 | $566.76 | $467.81 | $479.51 | $364.67 | $373.79 | $565.02 | $579.15 | $468.20 | $479.91 | $368.87 | $378.09 | $333.39 | $341.72 |
| 39 | $479.46 | $491.45 | $560.04 | $574.04 | $473.82 | $485.67 | $369.35 | $378.58 | $572.28 | $586.59 | $474.21 | $486.07 | $373.60 | $382.94 | $337.67 | $346.11 |
| 40 | $485.54 | $534.09 | $567.14 | $623.85 | $479.83 | $527.81 | $374.03 | $411.43 | $579.53 | $637.48 | $480.22 | $528.24 | $378.34 | $416.17 | $341.95 | $376.15 |
| 41 | $494.66 | $546.60 | $577.79 | $638.46 | $488.84 | $540.17 | $381.06 | $421.07 | $590.42 | $652.41 | $489.24 | $540.61 | $385.44 | $425.91 | $348.38 | $384.96 |
| 42 | $503.39 | $559.77 | $588.00 | $653.86 | $497.47 | $553.19 | $387.79 | $431.22 | $600.85 | $668.15 | $497.88 | $553.64 | $392.25 | $436.18 | $354.53 | $394.24 |
| 43 | $515.55 | $577.93 | $602.20 | $675.07 | $509.49 | $571.14 | $397.15 | $445.21 | $615.36 | $689.82 | $509.91 | $571.61 | $401.73 | $450.34 | $363.09 | $407.02 |
| 44 | $530.75 | $600.81 | $619.95 | $701.78 | $524.50 | $593.73 | $408.86 | $462.83 | $633.50 | $717.12 | $524.94 | $594.23 | $413.57 | $468.16 | $373.80 | $423.14 |
| 45 | $548.60 | $628.15 | $640.80 | $733.72 | $542.15 | $620.76 | $422.62 | $483.90 | $654.81 | $749.76 | $542.60 | $621.28 | $427.48 | $489.46 | $386.37 | $442.39 |
| 46 | $569.88 | $661.06 | $665.66 | $772.17 | $563.18 | $653.29 | $439.01 | $509.25 | $680.21 | $789.04 | $563.64 | $653.82 | $444.06 | $515.11 | $401.36 | $465.58 |
| 47 | $593.81 | $698.91 | $693.61 | $816.38 | $586.83 | $690.70 | $457.44 | $538.41 | $708.77 | $834.22 | $587.31 | $691.26 | $462.71 | $544.61 | $418.21 | $492.23 |
| 48 | $621.17 | $742.92 | $725.56 | $867.77 | $613.86 | $734.18 | $478.52 | $572.31 | $741.42 | $886.74 | $614.37 | $734.79 | $484.03 | $578.90 | $437.48 | $523.23 |
| 49 | $648.14 | $788.79 | $757.07 | $921.35 | $640.52 | $779.51 | $499.30 | $607.65 | $773.62 | $941.50 | $641.05 | $780.16 | $505.04 | $614.63 | $456.47 | $555.52 |
| 50 | $678.54 | $831.21 | $792.57 | $970.90 | $670.55 | $821.42 | $522.71 | $640.32 | $809.90 | $992.13 | $671.11 | $822.11 | $528.73 | $647.69 | $477.88 | $585.40 |
| 51 | $708.55 | $867.97 | $827.63 | $1,013.85 | $700.21 | $857.76 | $545.83 | $668.64 | $845.72 | $1,036.01 | $700.79 | $858.47 | $552.11 | $676.33 | $499.02 | $611.30 |
| 52 | $741.60 | $908.46 | $866.24 | $1,061.14 | $732.88 | $897.78 | $571.29 | $699.83 | $885.17 | $1,084.33 | $733.48 | $898.51 | $577.87 | $707.89 | $522.30 | $639.82 |
| 53 | $775.04 | $949.42 | $905.29 | $1,108.98 | $765.92 | $938.25 | $597.05 | $731.39 | $925.08 | $1,133.22 | $766.55 | $939.02 | $603.92 | $739.80 | $545.84 | $668.65 |
| 54 | $811.13 | $993.63 | $947.45 | $1,160.63 | $801.59 | $981.95 | $624.85 | $765.44 | $968.16 | $1,186.00 | $802.25 | $982.76 | $632.05 | $774.26 | $571.26 | $699.79 |
| 55 | $847.22 | $1,037.84 | $989.61 | $1,212.27 | $837.25 | $1,025.63 | $652.65 | $799.50 | $1,011.24 | $1,238.77 | $837.94 | $1,026.48 | $660.17 | $808.71 | $596.68 | $730.93 |
| 56 | $886.35 | $1,085.78 | $1,035.32 | $1,268.27 | $875.92 | $1,073.00 | $682.80 | $836.43 | $1,057.95 | $1,295.99 | $876.65 | $1,073.90 | $690.66 | $846.06 | $624.24 | $764.69 |
| 57 | $925.87 | $1,134.19 | $1,081.47 | $1,324.80 | $914.97 | $1,120.84 | $713.24 | $873.72 | $1,105.11 | $1,353.76 | $915.73 | $1,121.77 | $721.45 | $883.78 | $652.07 | $798.79 |
| 58 | $968.04 | $1,185.85 | $1,130.73 | $1,385.14 | $956.65 | $1,171.90 | $745.72 | $913.51 | $1,155.44 | $1,415.41 | $957.44 | $1,172.86 | $754.31 | $924.03 | $681.77 | $835.17 |
| 59 | $988.93 | $1,211.44 | $1,155.13 | $1,415.03 | $977.30 | $1,197.19 | $761.82 | $933.23 | $1,180.38 | $1,445.97 | $978.10 | $1,198.17 | $770.59 | $943.97 | $696.48 | $853.19 |
| 60 | $1,031.10 | $1,263.10 | $1,204.39 | $1,475.38 | $1,018.97 | $1,248.24 | $794.31 | $973.03 | $1,230.72 | $1,507.63 | $1,019.81 | $1,249.27 | $803.45 | $984.23 | $726.18 | $889.57 |
| 61 | $1,067.58 | $1,307.79 | $1,246.99 | $1,527.56 | $1,055.01 | $1,292.39 | $822.40 | $1,007.44 | $1,274.25 | $1,560.96 | $1,055.89 | $1,293.47 | $831.87 | $1,019.04 | $751.87 | $921.04 |
| 62 | $1,091.51 | $1,337.10 | $1,274.95 | $1,561.81 | $1,078.67 | $1,321.37 | $840.84 | $1,030.03 | $1,302.82 | $1,595.95 | $1,079.56 | $1,322.46 | $850.52 | $1,041.89 | $768.73 | $941.69 |
| 63 | $1,121.52 | $1,373.86 | $1,310.01 | $1,604.76 | $1,108.33 | $1,357.70 | $863.96 | $1,058.35 | $1,338.64 | $1,639.83 | $1,109.24 | $1,358.82 | $873.91 | $1,070.54 | $789.87 | $967.59 |
| 64 | $1,139.76 | $1,396.21 | $1,331.31 | $1,630.85 | $1,126.35 | $1,379.78 | $878.01 | $1,075.56 | $1,360.41 | $1,666.50 | $1,127.28 | $1,380.92 | $888.12 | $1,087.95 | $802.71 | $983.32 |
| 65+ | $1,139.76 | $1,396.21 | $1,331.31 | $1,630.85 | $1,126.35 | $1,379.78 | $878.01 | $1,075.56 | $1,360.41 | $1,666.50 | $1,127.28 | $1,380.92 | $888.12 | $1,087.95 | $802.71 | $983.32 |

## We're Here to Help

**We hope this step-by-step guide helps you choose your 2017 health insurance.**

**If we can answer any questions at any point, please:**

- Call us at **1-855-329-0694** (TTY/TDD 711)
- Visit **DiscoverHighmark.com**
- Talk to your local Highmark Delaware insurance agent

Or, visit the Health Insurance Marketplace at HealthCare.gov or call the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325) to review all your plan options.

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Visit us on Social Media.

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