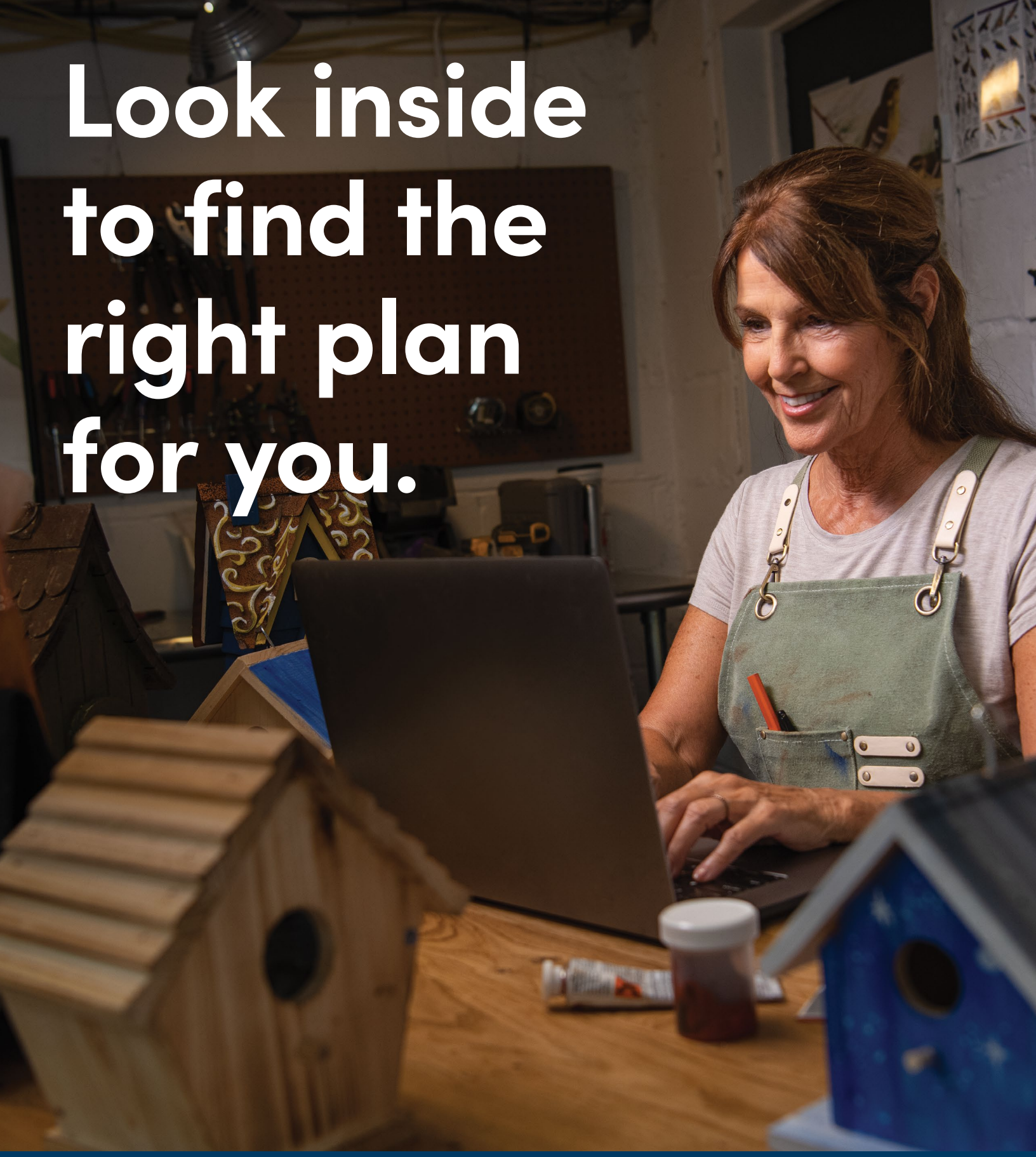


Look inside to find the right plan for you.

For Benefit Period:
January 1 to December 31, 2023

HIGHMARK. BLUE CROSS BLUE SHIELD
DELAWARE

Because Life.™

Go ahead. Get picky about your plan.

With lots of great coverage options from Highmark, this book will help you find the plan and product that matters most to you.

Looking for something in particular? You can easily navigate through the guide by clicking on the headings in the Table of Contents.

Table of Contents

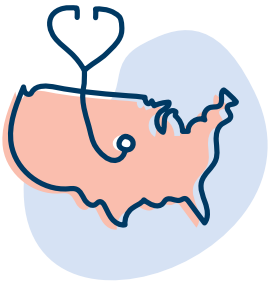
Why choose a Highmark health plan?

Woah. So many reasons. Here are three big ones right off the top of our heads.

1

Expert care, close to home.

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



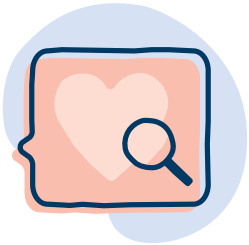
2

Coverage that travels with you.

All of our plans come with access to BlueCard®. You're connected to the largest physician and hospital networks in the U.S. with over 1.7 million providers, including 95% of all hospitals.*

BlueCard also gives you access to routine,** urgent, and emergency care, no matter where you are.

See page 20 for more information on BlueCard.



3

No red tape.

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

And that's just for starters.

Turn the page for even more reasons to choose Highmark.

* According to the Blue Cross and Blue Shield Association.
** Certain services may require you to work with your BlueCard-participating provider to obtain prior authorization.

How easy do we make it to find care and get care?

Almost too easy.

DENTAL AND VISION COVERAGE

All your care, all in one plan.

Healthy eyes and teeth are important parts of your overall health and regular checkups can help you stay ahead of potential problems down the road. That's why all of our plans come with pediatric dental and vision benefits.

Our plans with "Adult Dental and Vision" in their name include these benefits, so there's no need to purchase separate plans.

VIRTUAL HEALTH

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

Need to see a doctor but don't want to leave your couch? Get a diagnosis, treatment plan, or prescription any time, right from your phone or computer. Best of all, the same virtual health services provided by Amwell are also available through many in-network providers. That's laid-back-in-a-recliner easy.

BLUE DISTINCTION®

Easy access to top-performing specialists.

Only doctors who consistently deliver safe, effective treatments make the Blue Distinction list. You can cherry-pick a top-performing in-network specialist for any care you need. Use our Find a Doctor tool and look for the Blue Distinction logo next to their name.

How simple is it for you to get answers and reach your goals?

Super simple.

THE HIGHMARK MEMBER WEBSITE

Your entire plan at your fingertips.

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

HEALTH SAVINGS ACCOUNT

Helping you save for today and tomorrow.

Health savings accounts let you put money away for things like medical costs, vision and dental services, and prescriptions. They're available on qualified high-deductible plans with "HSA" in the plan name.

MY CARE NAVIGATOSM

Your appointments, booked for you.

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

BLUES ON CALLSM

Answers from a health pro, 24/7.

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

Before we get much further, let's cover some Affordable Care Act (ACA) essentials.

ACA basics

Metal levels

ACA plans* are broken into four categories based on how you and your plan share the costs of your health care.

Just so you know, metal levels reflect cost-sharing** differences only — which means you get the same quality of care at any level.

Bronze	Silver	Gold	Platinum	Extra Savings Silver
60% of costs covered by your plan	**70%** of costs covered by your plan	**80%** of costs covered by your plan	**90%** of costs covered by your plan	**73–94%** of costs covered by your plan
40% out-of-pocket costs	30% out-of-pocket costs	20% out-of-pocket costs	10% out-of-pocket costs	27–6% out-of-pocket costs
This level makes sense if you***: Don't use a lot of health care services and/or want to keep premium payments low.	This level makes sense if you***: Want to balance premiums with out-of-pocket costs.	This level makes sense if you***: Use health care services somewhat frequently and/or want low out-of-pocket costs for most commonly used services.	This level makes sense if you***: Use health care services frequently and/or want to keep out-of-pocket costs low for all services.	This level makes sense if you***: Are CSR-eligible, which gives you lower out-of-pocket costs.

* ACA also includes Catastrophic and Platinum level plans. Catastrophic plans are available if you're under 30 or have a financial hardship. They're for people who do not go to the doctor frequently or only go to the doctor when there's an emergency. Highmark does not offer Platinum plans in Pennsylvania.

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

*** Financial help in the form of APTCs or CSRs are available only on plans purchased through the Health Insurance Marketplace.

Ways to save

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

Even better news: More than 90% of our ACA members qualify to save.

Advance Premium Tax Credits (APTC), which may be applied — in advance — to lower what you pay each month for your premium on any level Marketplace plan except Catastrophic.

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. CSR plans offer lower deductibles, copays, and coinsurance. You can only get these savings if you enroll in an "Extra Savings" Silver plan.

You can qualify for both an APTC and CSR, too.

Extra ACA assistance

The Inflation Reduction Act lowers the cost of health plans for middle- and lower-income individuals and families. It may provide more aid even if you've previously qualified for financial help. And it makes it easier to qualify if you've been denied in the past.

Your savings can be significant. **See for yourself.**

Kyle

Single, 40 years old, non-smoker
Annual income: $19,140

Before: $66 monthly premium

After: $0 monthly premium

Savings: $792/year

Dean and Vanessa

Married couple, 64 years old, non-smokers
Annual income: $77,850

Before: $2,492 monthly premium

After: $550 monthly premium

Savings: $23,304/year

Premiums and Advance Premium Tax Credit (APTC) will vary by county. The APTC can lower the monthly premium. Examples are based on the second-lowest cost Silver plan available on the Marketplace in a given area. The price of this plan is used to calculate premium subsidies.

Financial help

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

Even if you don't qualify for cost-sharing reductions, you may be eligible for advance premium tax credits. Please refer to the Base plan options for your county.

Who needs coverage?	What is the income for those covered under your health plan?				
	Eligible for Medicaid	Eligible for CSRs and APTCs			Eligible for APTCs
	Medicaid Eligible Range (100–138% or less FPL)	Silver Extra Savings Plans			Base
		138–149% CSR plans	150–199% CSR plans	200–249% CSR plans	250% or more
Single	Less than $18,754	$18,755 – $20,384	$20,385 – $27,179	$27,180 – $33,974	$33,975 or more
Family of 2	Less than $25,268	$25,269 – $27,464	$27,465 – $36,619	$36,620 – $45,774	$45,775 or more
Family of 3	Less than $31,781	$31,782 – $34,544	$34,545 – $46,059	$46,060 – $57,574	$57,575 or more
Family of 4	Less than $38,295	$38,296 – $41,624	$41,625 – $55,499	$55,500 – $69,374	$69,375 or more
Family of 5	Less than $44,809	$44,810 – $48,704	$48,705 – $64,939	$64,940 – $81,174	$81,175 or more
Family of 6	Less than $51,322	$51,323 – $55,784	$55,785 – $74,379	$74,380 – $92,974	$92,975 or more
Family of 7	Less than $57,836	$57,837 – $62,864	$62,865 – $83,819	$83,820 – $104,774	$104,775 or more
Family of 8	Less than $64,349	$64,350 – $69,944	$69,945 – $93,259	$93,260 – $116,574	$116,575 or more

* Most individuals and families with household incomes 100% or more of the FPL will qualify for premium tax credits. These credits help lower the cost of health insurance coverage and are based on the second-lowest-cost Silver plan available in your area on the Health Insurance Marketplace. The second-lowest-cost Silver plan is also known as the "benchmark plan." Premium tax credits vary by income. Households with incomes 150% or less of the FPL will pay no premium for the benchmark plan. Those households with annual incomes 400% or more of the FPL will pay no more than 8.5% of their household income on health insurance premiums for the benchmark plan.
* Income below 138% FPL: If your income is below 138% FPL and your state has expanded Medicaid coverage, you qualify for Medicaid based only on your income.
* American Indians and Alaska Natives who are members of federally recognized tribes are eligible for cost-sharing reductions at alternative dollar thresholds.

This chart is only applicable for coverage in 2023 and in the 48 contiguous states and the District of Columbia. For families/households with more than 8 persons, add $4,720 for each additional person. HHS Poverty Guidelines for 2022 (March 3, 2022). Retrieved from **https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines**.

Check to see if you qualify for one or both types of help.
Call 855-882-6533.

ACA plans vs. short-term plans and Health Care Sharing Ministries

In addition to the availability of APTC and CSR, all ACA plans provide coverage for preexisting conditions and the 10 Essential Health Benefits (see page 19). Short-term plans and Health Care Sharing Ministries — which are plans that come with a fixed, limited term — do not. These plans can seem like a cheaper alternative to ACA coverage but often come with hidden costs and exclusions that can make them more expensive in the long run.

Other types of hidden costs in short-term and Health Care Sharing Ministries plans:

	SHORT-TERM PLANS AND HEALTH CARE SHARING MINISTRIES	ACA PLANS
Capped out-of-pocket spending	not included	included
Coverage of 10 Essential Health Benefits	not included	included
No limits on covered doctor visits	not included	included
No dollar limits on covered benefits	not included	included
No limits on prescription drug coverage	not included	included
Coverage for preexisting conditions with no waiting period	not included	included

A listing of the 10 Essential Health Benefits can be found on page 19.

Next, enrollment dates.

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

1 OPEN ENROLLMENT PERIOD
November 1, 2022 – January 15, 2023

If you sign up by December 15, 2022, your plan takes effect on January 1, 2023.

If you sign up between December 16, 2022, and January 15, 2023, your plan takes effect on February 1, 2023.

2 SPECIAL ENROLLMENT PERIODS
Can happen any time throughout the year

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

If you think you're eligible for a Special Enrollment Period, you may be asked to submit documents to verify it. You can go to highmark.com for more information.

Finally, your ACA Enrollment Checklist.

Here's the info you'll need for each person who will be covered on your plan.

- [ ] **Date of birth**

- [ ] **Social Security number**
(or legal immigrant documents)

- [ ] **Income documentation for all household members, even if they won't be covered by the plan**
(pay stubs, W-2 forms, or wage and tax statements)

- [ ] **Current health insurance policy numbers (if applicable)**

- [ ] **Info on any health insurance you or your family could get from your job**

All set? Great. Let's dig into the details for 2023 — **and find a plan with the benefits you want at price you can afford.**

2023 Highmark plan designs and network highlights

Now that we've gotten the preliminaries out of the way, let's take a look at the products and networks available in your area in 2023.

You get all the essentials.

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

They include:

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

my Blue Access PPO

Your choice for comprehensive in-network access throughout Delaware.

With a my Blue Access PPO* plan from Highmark Delaware, you have in-network access to high-quality, cost-effective care in Delaware, Maryland, New Jersey, and Pennsylvania, as well as at facilities like **ChristianaCare, Bayhealth, Beebe Medical Center, and Nemours Children's Hospital**. With a PPO, you also get the flexibility to see out-of-network providers.

To see if your provider is in network, visit highmarkbcbsde.com and click Find a Doctor or Pharmacy.

BlueCard coverage goes where you go.

Planning to hit the road or travel abroad this year? With BlueCard, your health care benefits go with you — across the country and around the world. We give you access to doctors and hospitals almost everywhere, so you'll have peace of mind that you can always find the care you need.

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

- Cleveland Clinic
- Johns Hopkins Hospital
- Memorial Sloan Kettering Cancer Center
- University of Maryland Medical Center

And, you're covered in 190 countries too. Keep in mind that BlueCard covers routine, emergency, and urgent care for most plans.

In-network facilities

Facilities
Kent County
Bayhealth Hospital - Kent Campus
New Castle County
ChristianaCare - Christiana Hospital
ChristianaCare - Wilmington Hospital
Delaware Psychiatric Center
Nemours Children's Hospital
Saint Francis Hospital
Select Specialty Hospital - Wilmington
Sussex County
Bayhealth Hospital - Sussex Campus
Beebe Medical Center
TidalHealth - Nanticoke Hospital

Facilities
Additional in-network facilities
The Johns Hopkins Hospital
TidalHealth - Peninsula Regional Medical Center
Memorial Sloan Kettering Cancer Center - Basking Ridge
Children's Hospital of Philadelphia
Einstein Medical Center Philadelphia
Penn Medicine - Hospital of the University of Pennsylvania
Penn Medicine - Pennsylvania Hospital

In addition to the out-of-state hospitals listed here, my Blue Access PPO plans all include all BlueCard providers across the country, as well as other out-of-state hospitals. Please refer to the provider directory for additional out-of-state hospitals. You can find the provider directory at **highmarkbcbsde.com** under the **Find a Doctor or Pharmacy** tab.

Premier Gold Plans

Our Premier Gold plans offer copays as low as $15. You'll also have lower out-of-pocket costs on covered services.

These plans include bonus benefits like a $25 over-the-counter quarterly allowance and access to programs like Papa and TruHearing.

Over-the-counter benefit

You'll get a $25 allowance on certain OTC products per quarter for every member covered by your plan. Use for things like minor wound care, ibuprofen, and allergy medication. It's convenient too. To place an order, visit **ShopHighmarkOTC.com**. Items are shipped directly to your home.

Papa

With Papa, you can get help with everyday tasks like light cleaning, laundry, grocery shopping, and getting to and from appointments. Papa also assists with meal prep, childcare, pets, and running errands. You'll even have access to companion caregivers nationwide and virtually. To learn more, visit **joinpapa.com/activities/video-visits**.

TruHearing

TruHearing™ can help lower copays on hearing aids. Plus, you can receive a hearing evaluation, as well as training, setup, fine-tuning, and adjustments from an in-network TruHearing provider without ever leaving your home. All you need is a smartphone, tablet, or computer. To learn more about TruHearing, visit **Highmark-HS.TruHearing.com**.

Bronze 6900 HSA — Custom Drug Benefit plan

This plan allows you to save for your care with a health savings account (HSA) and provides low out-of-pocket costs on select prescriptions.

An HSA lets you put money away into a savings account that you can use for things like medical costs, vision and dental services, and prescriptions.

With the custom drug benefit, Highmark pays 100% of the costs for preventive and maintenance drugs immediately. There's no need to meet the deductible. For a complete list of covered drugs, visit highmark.link/cdbde.

Free preventive and maintenance drugs include:

- Eliquis 5 mg tablet
- rosuvastatin calcium 5, 10, 20 mg tablet (Crestor)
- venlafaxine HCL ER 150 mg capsule (Effexor)
- Jardiance 10, 25 mg tablet
- ezetimibe 10 mg tablet (Zetia)
- Trulicity 1.5 mg/5.0 ml pen
- Ozempic 0.25–0.5 mg/dose pen
- Januvia 100 mg tablet
- Xarelto 20 mg tablet
- Breo Ellipta 100–25 mcg inhaler
- Symbicort 160–4.5 mcg inhaler

Also included in the list are 20 of the most filled prescriptions. They include drugs for things like diabetes, asthma, heart conditions, anxiety, and depression.

Plans that include adult vision and dental

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

You can find adult dental and vision benefits on pages 34-36 and pediatric dental and vision benefits at **highmark.com**.

Benefits of adult vision coverage:

- Free annual eye exam.
- Frame allowance* up to $150**.
- Contact allowance* up to $150***.

Our vision plans use the Davis Vision Network — a list of in-network providers can be accessed through **highmarkbcbsde.com**. To access network providers, select **Find a Doctor or Pharmacy**. Then click **Find an Eye Care Provider**. Select **Click here** to search the Health Care Reform Vision Network.

* Allowance is for either frames or contacts.
** Plus 20% discount on any overages.
*** Plus 15% discount on any overages.

Benefits of adult dental coverage:

- 100% coverage on cleanings,‡ X-rays, and sealants.
- 80% coverage on services like fillings and repairs of existing crowns.
- 50% coverage on services like root canals and new crowns.

Our plans use the Concordia Advantage network. To find a provider, visit **highmarkbcbsde.com** and select the **Find a Doctor or Pharmacy** tab.

‡ Two cleanings per year.

IT PAYS TO HAVE DENTAL COVERAGE

Service	Average cost with dental coverage	Average cost without dental coverage *(usual fee)*
Exams, cleanings, and X-rays	$0-37	$300[1]
Composite filling	$71	$170[2]
Simple extraction	$33	$163[3]
Root canal	$400	$1,250[4]

[1] https://www.dentaly.org/us/oral-hygiene/teeth-cleaning/#How_much_does_a_dental_cleaning_cost, last accessed June 15, 2022
https://www.dentaly.org/us/panoramic-dental-xray/, last accessed June 15, 2022

[2] https://www.dentaly.org/us/tooth-filling/#How_much_do_fillings_cost, last accessed June 15, 2022

[3] https://www.dentaly.org/us/tooth-extraction/#How_much_does_tooth_removal_cost_in_the_US, last accessed June 15, 2022

[4] https://www.webmd.com/oral-health/guide/dental-root-canals, last accessed June 15, 2022

Now, let's dig into plan details.

To learn about our plan names, flip to page 38.

You'll see plan summaries here. If you want any plan's full benefit list, visit shop.highmark.com/sales/#!/sbcs or get a paper copy by calling 1-833-258-0188 (TTY/TDD 711).

	Coverage Level			
	Catastrophic 9100 — 3 Free PCP Visits	**Standard Bronze 9100**	**Bronze 6900 HSA —** Custom Drug Benefit	**Bronze 3800**
Plan Availability	my Blue Access Major Events PPO 9100 — 3 Free PCP Visits	my Blue Access PPO Standard Bronze 9100	my Blue Access PPO Bronze 6900 HSA - Custom Drug Benefit	my Blue Access PPO Bronze 3800
In-Network Deductible	Individual: $9,100 Family: $18,200	Individual: $9,100 Family: $18,200	Individual: $6,900 Family: $13,800	Individual: $3,800 Family: $7,600
In-Network, Out-of-Pocket Maximum	Individual: $9,100 Family: $18,200	Individual: $9,100 Family: $18,200	Individual: $6,900 Family: $13,800	Individual: $9,100 Family: $18,200
Primary Care Visit	$0 after deductible; first 3 visits $0 (not subject to deductible)	$0 after deductible	$0 after deductible	$75 copay
Specialist Visit	$0 after deductible	$0 after deductible	$0 after deductible	$75 copay
Outpatient Mental Health and Substance Abuse Visits	$0 after deductible	$0 after deductible	$0 after deductible	$75 copay
Physical and Occupational Therapy and Chiropractic Care[2]	$0 after deductible	$0 after deductible	$0 after deductible	$17 copay
Diagnostic Test (Lab/X-ray)	$0 after deductible	$0 after deductible	$0 after deductible	Lab: $65 copay X-ray: $140 copay
Urgent Care[6]	$0 after deductible	$0 after deductible	$0 after deductible	$100 copay
Emergency Services	$0 after deductible	$0 after deductible	$0 after deductible	50% after deductible
Hospital Inpatient (including Maternity)[3]	$0 after deductible	$0 after deductible	$0 after deductible	50% after deductible
Pharmacy Summary[4]	$0/$0/$0/$0 after deductible	$0/$0/$0/$0 after deductible	$0/$0/$0/$0 after deductible	50%/50%/50%/50% after deductible
Includes Adult Dental and Vision Option[5]	No	No	No	Yes

	Coverage Level				
	Silver 5900	**Standard Silver 5800**	**Silver 3500[1]**	**Standard Gold 2000**	**Gold 1700 HSA[1]**
Plan Availability	my Blue Access PPO Silver 5900	my Blue Access PPO Standard Silver 5800	my Blue Access PPO Silver 3500[1]	my Blue Access PPO Standard Gold 2000	my Blue Access PPO Gold 1700 HSA[1]
In-Network Deductible	Individual: $5,900 Family: $11,800	Individual: $5,800 Family: $11,600	Individual: $3,500 Family: $7,000	Individual: $2,000 Family: $4,000	Individual: $1,700 Family: $3,400
In-Network, Out-of-Pocket Maximum	Individual: $9,100 Family: $18,200	Individual: $8,900 Family: $17,800	Individual: $9,100 Family: $18,200	Individual: $8,700 Family: $17,400	Individual: $5,700 Family: $11,400
Primary Care Visit	$55 copay	$40 copay	$40 copay	$30 copay	$20 after deductible
Specialist Visit	$55 copay	$80 copay	$40 copay	$60 copay	$20 after deductible
Outpatient Mental Health and Substance Abuse Visits	$55 copay	$40 copay	$40 copay	$30 copay	$20 after deductible
Physical and Occupational Therapy and Chiropractic Care[2]	$17 copay	$17 copay	$17 copay	$17 copay	$17 after deductible
Diagnostic Test (Lab/X-ray)	$75 copay	40% after deductible	$75 copay	25% after deductible	$20 after deductible
Urgent Care[6]	$110 copay	$60 copay	$80 copay	$45 copay	$40 after deductible
Emergency Services	$750 after deductible	40% after deductible	40% after deductible	25% after deductible	$175 after deductible
Hospital Inpatient (including Maternity)[3]	$900 after deductible	40% after deductible	40% after deductible	25% after deductible	$300 after deductible
Pharmacy Summary[4]	$0/$30/$150/50%	$20/$40/$80*/$125*	$0/$50/$225/50%	$15/$30/$60/$100	$0/$30/$150/50% after deductible
Includes Adult Dental and Vision Option[5]	No	Yes	Yes	No	No

[1] These plans are available directly from Highmark and are not available on the Health Insurance Exchange. They do not qualify for Advanced Premium Tax Credits or Cost-Sharing Reductions.

[2] Limit of 30 combined physical and occupational therapy visits per benefit period. Limit does not apply to the treatment of back pain by chiropractors and physical therapists or when therapy services are prescribed for the treatment of a Mental Health or Substance Abuse diagnosis.

[3] The hospital copay applies to admission. Additional copays may be due for imaging, testing, etc. Please refer to the plans contract for additional information.

[4] Visit **highmarkacaformulary.com** to view our Formulary and see if your drug is covered, and at which tier.

[5] See page 34-36 for Adult Dental and Vision benefit details.

[6] The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental illness or substance abuse.

* After deductible.

	Coverage Level			
	Gold 0	**Premier Gold 0**	**Platinum 0**	**Standard Platinum 0**
Plan Availability	my Blue Access PPO Gold 0	my Blue Access PPO Premier Gold 0	my Blue Access PPO Platinum 0	my Blue Access PPO Standard Platinum 0
In-Network Deductible	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network, Out-of-Pocket Maximum	Individual: $7,500 Family: $15,000	Individual: $6,500 Family: $13,000	Individual: $5,000 Family: $10,000	Individual: $3,000 Family: $6,000
Primary Care Visit	$20 copay	$15 copay	$5 copay	$10 copay
Specialist Visit	$20 copay	$15 copay	$5 copay	$20 copay
Outpatient Mental Health and Substance Abuse Visits	$20 copay	$15 copay	$5 copay	$10 copay
Physical and Occupational Therapy and Chiropractic Care[2]	$17 copay	$15 copay	$5 copay	$10 copay
Diagnostic Test (Lab/X-ray)	$50 copay	$40 copay	$10 copay	$30 copay
Urgent Care[6]	$40 copay	$30 copay	$10 copay	$15 copay
Emergency Services	$300 copay	$250 copay	$100 copay	$100 copay
Hospital Inpatient (including Maternity)[3]	$500 copay	$375 copay	$250 copay	$350 copay
Pharmacy Summary[4]	$0/$30/$150/50%	$0/$25/$75/50%	$0/$10/$50/50%	$5/$10/$50/$75
Includes Adult Dental and Vision Option[5]	Yes	Yes	Yes	No

[1] These plans are available directly from Highmark and are not available on the Health Insurance Exchange. They do not qualify for Advanced Premium Tax Credits or Cost-Sharing Reductions.

[2] Limit of 30 combined physical and occupational therapy visits per benefit period. Limit does not apply to the treatment of back pain by chiropractors and physical therapists or when therapy services are prescribed for the treatment of a Mental Health or Substance Abuse diagnosis.

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[5] See page 34-36 for Adult Dental and Vision benefit details.

[6] The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental illness or substance abuse.

	Income Level		
	138-149% FPL		150-199% FPL
	Coverage Level		
	Extra Savings Silver 94% of costs covered by your plan 6% out-of-pocket costs		Extra Savings Silver 87% of costs covered by your plan 13% out-of-pocket costs
	Silver 0	Premier Silver 0	Silver 0
Plan Availability	my Blue Access PPO Extra Saving Silver 0	my Blue Access PPO Standard Extra Savings Silver 0	my Blue Access PPO Extra Savings Silver 0
In-Network Deductible	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network, Out-of-Pocket Maximum	Individual: $1,200 Family: $2,400	Individual: $1,800 Family: $3,600	Individual: $2,800 Family: $5,600
Primary Care Visit	$1 copay	$0 copay	$15 copay
Specialist Visit	$1 copay	$10 copay	$15 copay
Outpatient Mental Health and Substance Abuse Visits	$1 copay	$0 copay	$15 copay
Physical and Occupational Therapy and Chiropractic Care[1]	$1 copay	$0 copay	$15 copay
Diagnostic Test (Lab/X-ray)	$5 copay	25% coinsurance	$25 copay
Urgent Care[5]	$5 copay	$5 copay	$30 copay
Emergency Services	$75 copay	25% coinsurance	$275 copay
Hospital Inpatient (including Maternity)[2]	$100 copay	25% coinsurance	$375 copay
Pharmacy Summary[3]	$0/$5/$15/50%	$0/$5/$10/$20	$0/$10/$50/50%
Includes Dental and Vision Option[4]	No	Yes	No

	Income Level		
	150-199% FPL	200-249% FPL	
	Coverage Level		
	Extra Savings Silver 87% of costs covered by your plan 13% out-of-pocket costs	Extra Savings Silver 73% of costs covered by your plan 27% out-of-pocket costs	
	Premium Silver 0	Silver 5000	Premier Silver 2100
Plan Availability	my Blue Access PPO Standard Extra Savings Silver 800	my Blue Access PPO Extra Savings Silver 5000	My Blue Access PPO Standard Extra Savings Silver 5700
In-Network Deductible	Individual: $800 Family: $1,600	Individual: $5,000 Family: $10,000	Individual: $4,100 Family: $8,200
In-Network, Out-of-Pocket Maximum	Individual: $3,000 Family: $6,000	Individual: $6,900 Family: $13,800	Individual: $7,200 Family: $14,400
Primary Care Visit	$20 copay	$55 copay	$40 copay
Specialist Visit	$40 copay	$55 copay	$80 copay
Outpatient Mental Health and Substance Abuse Visits	$20 copay	$55 copay	$40 copay
Physical and Occupational Therapy and Chiropractic Care[1]	$17 copay	$17 copay	$17 copay
Diagnostic Test (Lab/X-ray)	30% after deductible	$75 copay	40% after deductible
Urgent Care[5]	$30 copay	$110 copay	$60 copay
Emergency Services	30% after deductible	$750 after deductible	40% after deductible
Hospital Inpatient (including Maternity)[2]	30% after deductible	$900 after deductible	40% after deductible
Pharmacy Summary[3]	$10/$20/$60*/$100*	$0/$30/$150/50%	$20/$40/$80*/$125*
Includes Dental and Vision Option[4]	Yes	No	Yes

[1] Limit of 30 combined physical and occupational therapy visits per benefit period. Limit does not apply to the treatment of back pain by chiropractors and physical therapists or when therapy services are prescribed for the treatment of a Mental Health or Substance Abuse diagnosis.

[2] The hospital copay applies to admission. Additional copays may be due for imaging, testing, etc. Please refer to the plan's contract for additional information.

[3] Visit **highmarkacaformulary.com** to view our Formulary and see if your drug is covered, and at which tier.

[4] See page 34-36 for Adult Dental and Vision benefit details.

[5] The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental illness or substance abuse.

* After deductible.

For all plans with Adult Dental and Vision — these are your vision benefits.

In-network

Vision Benefits	Frequency - Once Every:
Eye Examination (including dilation when professionally indicated)	12 months
Spectacle Lenses	12 months
Frame	12 months
Contact Lenses (in lieu of eyeglass lenses)	12 months

Copayments	
Eye Examination	$0
Spectacle Lenses	$0
Contact Lens Evaluation, Fitting, and Follow-Up Care	n/a

Eyeglass Benefit - Frame		Average Retail Value	
Non-Collection Frame Allowance (Retail):		Up to $130	Up to $150
Davis Vision Frame Collection[1] (in lieu of Allowance):	Fashion level	Up to $125	Included
	Designer level	Up to $175	$20 copayment
	Premier level	Up to $225	$40 copayment

Eyeglass Benefit - Spectacle Lenses	Average Retail Value	Member Charges
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any Rx)	$60-$120	Included
Oversize Lenses	$20	Included
Tinting of Plastic Lenses	$20	$11
Scratch-Resistant Coating	$25-$40	Included
Scratch Protection Plan Single Vision	$60-$120	$20
Scratch Protection Plan Multifocal	$60-$120	$40
Polycarbonate Lenses[2]	$60-$75	$0 or $30
Ultraviolet Coating	$25-$30	$12
Standard Anti-Reflective (AR) Coating	$50-$70	$35
Premium AR Coating	$65-$90	$48
Ultra AR Coating	$100-$125	$60
Standard Progressive Lenses	$150-$195	$50
Premium Progressives (Varilux®, etc.)	$195-$225	$90
Ultra Progressive Lenses	$225-$300	$140
Intermediate-Vision Lenses	$150-$175	$30
High-Index Lenses	$90-$150	$55
Polarized Lenses	$95-$110	$75
Plastic Photosensitive Lenses	$95-$150	$65

Contact Lens Benefit (in lieu of eyeglasses)		
Non-Collection Contact Lenses: Materials Allowance		Up to $150
Collection Contact Lenses[1] (in lieu of Allowance): Materials	Disposable	Covered In Full
	Planned Replacement	Covered In Full
	Evaluation, Fitting, and Follow-up Care	Included
Medically Necessary Contact Lenses (with prior approval)	Materials, Evaluation, Fitting, and Follow-Up Care	Included

[1] Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

[2] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included.

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

To find a provider in the Davis Vision Network, visit **highmarkbcbsde.com** and select the **Find a Doctor or Pharmacy** tab.

For all plans with Adult Dental and Vision — these are your vision benefits.

Dental Benefits			
Annual Deductible Per Insured Person		$50 Per Calendar Year	
Annual Deductible Per Insured Family		$150 Per Calendar Year	
Annual Maximum Per Insured Person		$1,250	
Covered Services:	Policy Pays		Elimination Period
	In Network	Out of Network	
Oral Evaluations (Exams)	100%	0%	None
Radiographs (All X-Rays)	100%	0%	None
Prophylaxis (Cleanings)	100%	0%	None
Palliative Treatment (Emergency)	100%	0%	None
Sealants	100%	0%	None
Space Maintainers	100%	0%	None
Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures , and Dentures	80%	0%	6 Months
Basic Restorative (Fillings, etc.)	80%	0%	None
Simple Extractions	80%	0%	6 Months
Surgical Extractions	50%	0%	6 Months
Complex Oral Surgery	50%	0%	6 Months
Endodontics (Root canals, etc.)	50%	0%	6 Months
General Anesthesia and/or Nitrous Oxide and/or IV Sedation	80%	0%	6 Months
Nonsurgical Periodontics	50%	0%	6 Months
Periodontal Maintenance	50%	0%	None
Surgical Periodontics	50%	0%	6 Months
Crowns, Inlays, Onlays	50%	0%	6 Months
Prosthetics (Fixed Partial Dentures, Dentures)	50%	0%	6 Months
Adjustments and Repairs of Prosthetics	80%	0%	None
Implant Services	0%	0%	None
Consultations	100%	0%	None
Orthodontics	0%	0%	None

The percentage in the Policy Pays column is the percentage of the Policy's Maximum Allowable Charge that the Policy will pay for Covered Services provided by a Participating Dentist. Participating Dentists accept the Maximum Allowable Charge as payment in full.

Adult Dental benefits utilize the Concordia Advantage Network. Members must use a United Concordia provider. There is no Out-of-Network coverage for this benefit. United Concordia Companies, Inc., is a separate company that administers pediatric dental benefits for Highmark Blue Cross Blue Shield Delaware members.

To find a dental provider in the Advantage Network, visit **highmarkbcbsde.com** and select the **Find a Doctor or Pharmacy** tab.

Health care lingo, translated.

When you're choosing plans, you're bound to see certain terms over and over. Here's a cheat sheet for a few of the most important ones.

BLUECARD
A program that connects independent Blue Plans across the country. It gives Blue Plan members access to in-network coverage while outside their plan area. The level of coverage depends on your chosen plan.

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

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

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

EMERGENCY SERVICES
Care for a condition needing immediate attention to avoid severe harm.

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

HABILITATIVE SERVICES
Health care services that help you keep, acquire, or improve skills and functioning for daily living following disease, illness, or injury.

HEALTH SAVINGS ACCOUNT (HSA)
An account to set aside pre-tax money to pay for qualified medical expenses. You can only have an HSA if you have a Qualified High-Deductible Health Plan.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)
A plan that usually comes with a lower premium because you pay more for health care services up front before the insurance company starts to pay. These plans are often combined with a health savings account.

IN-NETWORK PROVIDER
A doctor or hospital that has an agreement with the plan and will accept plan allowance plus member copay or coinsurance as payment in full.

OUT-OF-NETWORK PROVIDER
A doctor or hospital that does not have an agreement with the plan and does not have to accept plan allowance as payment in full.

OUT-OF-POCKET MAXIMUM
The most you'd pay for covered care in a benefit period or year. If you reach this amount, your plan pays 100% after that.

PLAN ALLOWANCE
The set amount an in-network provider has agreed to accept for a covered health care service. Member responsibility for the service can be found in the Schedule of Benefits. The plan pays the difference between the plan allowance and the member responsibility. If an out-of-network provider bills for more than the plan allowance, you may have to pay the difference. If your plan does not include out-of-network coverage and you receive care, other than emergency or urgent care, you may be responsible for the entire cost.

PREMIUM
The monthly amount paid for coverage.

PREVENTIVE CARE SERVICES
Routine care like screenings and checkups that help keep you healthy. Refer to the Highmark Preventive Schedule for the list of preventive care services.

PRIMARY CARE PROVIDER (PCP)
The medical professional you see for most of your basic care, like yearly preventive visits and screenings.

QUALIFIED HEALTH PLAN (QHP)
A plan that has been certified by the Health Insurance Marketplace and meets all ACA requirements. That includes providing the 10 Essential Health Benefits and staying inside the limits for deductibles, copays, and out-of-pocket maximums.

REHABILITATIVE SERVICES
Care that helps you keep, get back, or improve skills and functioning after you were sick, hurt, or disabled.

RETAIL CLINIC
Walk-in centers for less complex health needs, generally open in the evenings and on weekends.

TELEMEDICINE
Telemedicine is health care that you get from a doctor remotely via a smart device, computer, or telephone.

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

VIRTUAL VISIT
A type of telemedicine that you receive from a PCP or specialist via electronic communications or online videoconferencing.

It’s all in the name.

Here’s a quick glance at how our plan names are built and what each part means for you.

Example shown: my Blue Access PPO Premier Extra Savings Silver 0 + Adult Dental and Vision

This is the **product type**. To learn more about our products and networks, flip to **page 20**.

my Blue Access **PPO** **Premier** **Extra Savings Silver**

It all starts with the **product name**. This corresponds to the available network.

This refers to unique benefits. To learn more, see **page 22**.

Metal level reflects how you and your plan share costs. See **page 11** for more info.

0 + Adult Dental and Vision

The plan's **deductible amount** will always follow the metal level.

This section refers to **additional benefits** included with the plan.

You might see **HSA** or **Custom Drug Benefit** in a plan name too.

You may also see Standard here. These plans have the same cost sharing across insurers on **healthcare.gov**.

There's a whole lot of legalese around these plans. We put it all in one place for you.

HIGHMARK DISCLOSURES

Important Benefit Details

Non-Embedded Family Deductible: For a Certificate covering more than one (1) family member, the family deductible must be satisfied before the plan will begin to pay benefits for covered services for any covered family member. When the family deductible has been satisfied, the family deductible will be considered to have been satisfied for all family members, the plan will begin to pay benefits for covered services for all covered family members for the remainder of the benefit period (January 1, 2023– December 31, 2023). The family deductible can be met by one family member or a combination of members.

Aggregate/Embedded Family Deductible Plans: For a Certificate 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, 2023– December 31, 2023), whether or not the entire family Deductible has been satisfied. When the family Deductible has been satisfied, the family Deductible will be considered to have been satisfied for all remaining covered family members. Not every individual member must meet the individual deductible for the family deductible to be met and no individual member may satisfy the entire family Deductible.

You are responsible for out-of-pocket costs each benefit period (January 1, 2023 – December 31, 2023) up to the maximum amount shown. Thereafter, the plan pays 100% of the Plan Allowance. During the remainder of the benefit period. This amount does not include amounts in excess of the plan allowance.

Diagnostic Lab services include Laboratory and Pathology. Diagnostic Lab services require one copay (or, for some plans, coinsurance after deductible) per date of service and type of service.

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. Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse.

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

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

Essential Formulary prescription drug cost covers a 90-day (Mail Order) or 34/60/90-day (Retail) supply. All plans have a four-tier closed formulary prescription drug structure.

Qualified High Deductible Health Plans may be coupled with a Health Savings Account (HSA). However, certain Cost-Sharing Reductions (CSR) or plan variations of this plan that are offered through the Health Insurance Marketplace are not intended to be used with an HSA. If you have questions, please check with your financial advisor.

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

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

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

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 certificate. Any review of materials, request for information, or application does not obligate you to enroll for coverage. Please request the Outline of Coverage for details on benefits, conditions, and exclusions. Providing your information is voluntary.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers visit our website. Go to highmark.com and enter your ZIP code. Select Plans followed by Shop Individual and Family Plans. Scroll to the blue bar at bottom of the page. Look for Be Informed and select Quality Assurance. For a paper copy, call 1-855-873-4108 (TTY/TDD 711).

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

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

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

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

Blues on Call is a service mark of the Blue Cross Blue Shield Association.

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 2023.

Amwell is an independent company that provides telemedicine services. Amwell does not provide Blue Cross and/or Blue Shield products or services and it is solely responsible for its telemedicine services.

Sharecare, RealAge Test and AskMD are registered trademarks of Sharecare, LLC., an independent and separate company that provides a consumer care engagement platform for Highmark members. Sharecare is solely responsible for its programs and services, which are not a substitute for professional medical advice, diagnosis or treatment. Sharecare does not endorse any specific product service or treatment. Health care plans and the benefits thereunder are subject to the terms of the applicable benefit agreement.

My Care Navigator is a service mark of Highmark Inc.

Papa is a separate company that provides companionship and assistance with everyday tasks to Highmark members.

TruHearing is a separate company that provides hearing aid devices and services that TruHearing is providing to Highmark or Highmark members.

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross Blue Shield Association.

All references to "Highmark" in this communication are references to Highmark Inc., an independent licensee of the Blue Cross Blue Shield Association, and/or to one or more of its affiliated Blue companies.

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

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.

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

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

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

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 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.

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

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 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.

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

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 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 .

Highmark, a member of the Blue Cross Blue Shield Association,* has been providing secure and stable health care coverage for over 80 years. With 1 in 3 Americans covered by a Blue Cross and/or Blue Shield plan, when you're with Highmark, you're in good company.

* The Blue Cross Blue Shield Association is an association of independent Blue Cross Blue Shield plans.

Ready to (en)roll?

Cool. Here's how to do it:

- By phone: 1-855-882-6533
- Online: Highmark.com
- By contacting your agent or broker

HIGHMARK. DELAWARE

Because Life.™

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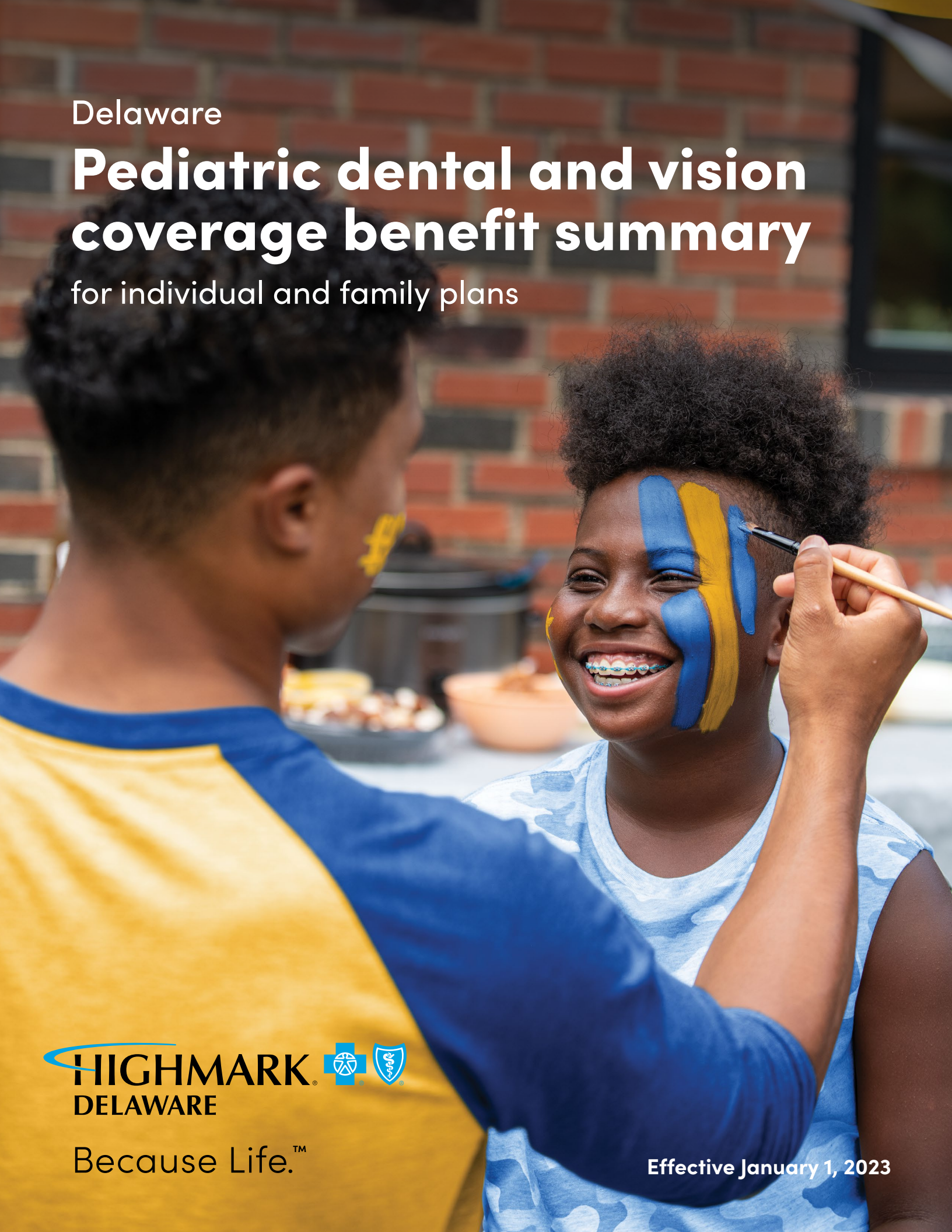

Delaware

Pediatric dental and vision coverage benefit summary

for individual and family plans

HIGHMARK DELAWARE

Because Life.™

Effective January 1, 2023

2023 Pediatric Vision Coverage Benefit Summary

NETWORK BENEFIT (Independents and Visionworks)*	Frequency	Child Pediatric – Members under 19 years of age[1]
Eye examination inclusive of dilation (when professionally indicated)	12 Months	$0 copay
Spectacle lenses[2]	12 Months	$0 copay
Frames	12 Months	$0 copay
Contact lens evaluation, fitting, and follow-up care (in lieu of eyeglasses)	12 Months	$0 copay
Contact lenses (in lieu of eyeglasses)	12 Months	$0 copay
Eyeglass benefit – frame		
Frame allowance (retail):	Up to $150 Plus a 20% discount on any overage	
Davis Vision Exclusive Collection (in lieu of allowance)		
Fashion / Designer / Premier - member charge (if applicable)	$0 / $0 / $0	
Eyeglass benefit – spectacle lenses[2]		
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	$0	
Digital single vision (intermediate)	$30	
Tinting of plastic lenses (solid / gradient)	$11	
Scratch-resistant coating	$0	
Polycarbonate lenses	$0	
Ultraviolet coating	$12	
Blue-light filtering	$15	
Anti-reflective (AR) coating (standard / premium / ultra / ultimate)	$35 / $48 / $60 / $85	
Progressive lenses[3] (standard / premium / ultra / ultimate)	$50 / $90 / $140 / $175	
High-index lenses (thinner and lighter)	$55 / $120	
Polarized lenses	$75	
Plastic photochromic lenses	$65	
Scratch protection plan: single vision / multifocal lenses	$20 / $40	
Contact lens benefit (in lieu of eyeglasses)		
Contact lens: materials allowance	Up to $150 Plus a 15% discount on any overage	
Evaluation, fitting, and follow-up care – standard and specialty lens types	Not Covered	
Evaluation, fitting, and follow-up care – standard lens types	Not Covered	
Exclusive Collection contact lenses[4] (in lieu of allowance):		
Materials: disposable or planned replacement	Up to 4 or 2 boxes	
Evaluation, fitting, and follow-up care	$0	
Visually required contact lenses (with prior approval) - Materials, evaluation, fitting, and follow-up care	$0 with prior approval	

These benefits apply to all plans other than High-Deductible and Catastrophic health plans.

[1] Dependents will be terminated from vision coverage at the end of the month in which they turn 19.
[2] Includes glass, plastic, or oversized lenses.
[3] Progressive multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive lenses. However, the member's payment toward the progressive upgrade will not be refunded.
[4] Disposable contact lens wearers will receive four multipacks of lenses. Planned replacement lens wearers will receive two multipacks of lenses.
* Vision benefits utilize the Davis Vision Network. There is no out-of-network coverage. Davis Vision is a separate company that administers Highmark vision benefits. Visionworks, also a separate company, is a provider within the Davis Vision Network.

2023 Pediatric Vision Coverage Benefit Summary

NETWORK BENEFIT (Independents and Visionworks)*	Frequency	Child Pediatric – Members under 19 years of age[1]
Eye examination inclusive of dilation (when professionally indicated)	12 Months	$0 copay
Spectacle lenses[2]**	12 Months	$0 copay
Frames**	12 Months	$0 copay
Contact lens evaluation, fitting, and follow-up care (in lieu of eyeglasses)	12 Months	$0 copay
Contact lenses (in lieu of eyeglasses)**	12 Months	$0 copay
Eyeglass benefit – frame		
Frame allowance (retail):	Up to $150 Plus a 20% discount on any overage	
Davis Vision Exclusive Collection (in lieu of allowance)		
Fashion / Designer / Premier - member charge (if applicable)	$0 / $0 / $0	
Eyeglass benefit – spectacle lenses[2]		
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	$0	
Digital single vision (intermediate)	$30	
Tinting of plastic lenses (solid / gradient)	$11	
Scratch-resistant coating	$0	
Polycarbonate lenses	$0	
Ultraviolet coating	$12	
Blue-light filtering	$15	
Anti-reflective (AR) coating (standard / premium / ultra / ultimate)	$35 / $48 / $60 / $85	
Progressive lenses[3] (standard / premium / ultra / ultimate)	$50 / $90 / $140 / $175	
High-index lenses (thinner and lighter)	$55 / $120	
Polarized lenses	$75	
Plastic photochromic lenses	$65	
Scratch protection plan: single vision / multifocal lenses	$20 / $40	
Contact lens benefit (in lieu of eyeglasses)		
Contact lens: materials allowance	Up to $150 Plus a 15% discount on any overage	
Evaluation, fitting, and follow-up care – standard and specialty lens types	Not Covered	
Evaluation, fitting, and follow-up care – standard lens types	Not Covered	
Exclusive Collection contact lenses[4] (in lieu of allowance):		
Materials: disposable or planned replacement	Up to 4 or 2 boxes	
Evaluation, fitting, and follow-up care	$0	
Visually required contact lenses (with prior approval) - Materials, evaluation, fitting, and follow-up care	$0 with prior approval	

These benefits apply to High-Deductible plans.

[1] Dependents will be terminated from vision coverage at the end of the month in which they turn 19.
[2] Includes glass, plastic, or oversized lenses.
[3] Progressive multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive lenses. However, the member's payment toward the progressive upgrade will not be refunded.
[4] Disposable contact lens wearers will receive four multipacks of lenses. Planned replacement lens wearers will receive two multipacks of lenses.
* Vision benefits utilize the Davis Vision Network. There is no out-of-network coverage. Davis Vision is a separate company that administers Highmark vision benefits. Visionworks, also a separate company, is a provider within the Davis Vision Network.
** Subject to deductible.

2023 Pediatric Vision Coverage Benefit Summary

NETWORK BENEFIT (Independents and Visionworks)*	Frequency	Child Pediatric – Members under 19 years of age[1]
Eye examination inclusive of dilation (when professionally indicated)**	12 Months	$0 copay
Spectacle lenses[2]**	12 Months	$0 copay
Frames**	12 Months	$0 copay
Contact lens evaluation, fitting, and follow-up care (in lieu of eyeglasses)**	12 Months	$0 copay
Contact lenses (in lieu of eyeglasses)**	12 Months	$0 copay
Eyeglass benefit – frame		
Frame allowance (retail):	Up to $150 Plus a 20% discount on any overage	
Davis Vision Exclusive Collection (in lieu of allowance)		
Fashion / Designer / Premier - member charge (if applicable)	$0 / $0 / $0	
Eyeglass benefit – spectacle lenses[2]		
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	$0	
Digital single vision (intermediate)	$30	
Tinting of plastic lenses (solid / gradient)	$11	
Scratch-resistant coating	$0	
Polycarbonate lenses	$0	
Ultraviolet coating	$12	
Blue-light filtering	$15	
Anti-reflective (AR) coating (standard / premium / ultra / ultimate)	$35 / $48 / $60 / $85	
Progressive lenses[3] (standard / premium / ultra / ultimate)	$50 / $90 / $140 / $175	
High-index lenses (thinner and lighter)	$55 / $120	
Polarized lenses	$75	
Plastic photochromic lenses	$65	
Scratch protection plan: single vision / multifocal lenses	$20 / $40	
Contact lens benefit (in lieu of eyeglasses)		
Contact lens: materials allowance	Up to $150 Plus a 15% discount on any overage	
Evaluation, fitting, and follow-up care – standard and specialty lens types	Not Covered	
Evaluation, fitting, and follow-up care – standard lens types	Not Covered	
Exclusive Collection contact lenses[4] (in lieu of allowance):		
Materials: disposable or planned replacement	Up to 4 or 2 boxes	
Evaluation, fitting, and follow-up care	$0	
Visually required contact lenses (with prior approval) - Materials, evaluation, fitting, and follow-up care	$0 with prior approval	

These benefits apply to Catastrophic health plans.

[1] Dependents will be terminated from vision coverage at the end of the month in which they turn 19.

[2] Includes glass, plastic, or oversized lenses.

[3] Progressive multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive lenses. However, the member's payment toward the progressive upgrade will not be refunded.

[4] Disposable contact lens wearers will receive four multipacks of lenses. Planned replacement lens wearers will receive two multipacks of lenses.

* Vision benefits utilize the Davis Vision Network. There is no out-of-network coverage. Davis Vision is a separate company that administers Highmark vision benefits. Visionworks, also a separate company, is a provider within the Davis Vision Network.

** Subject to deductible.

2023 Pediatric Dental Coverage Benefit Summary

These benefits apply to all plans except Catastrophic or High Deductible health plans.

This plan meets the minimum essential health benefit requirements for pediatric oral health as required under the Federal Affordable Care Act.

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

This plan will pay benefits for Covered Services shown below subject to exclusions and other Policy terms. Payment is based on the plan allowance for the specific Covered Service. **Participating Dentists accept contracted plan allowance as payment in full for services.**

Contract year deductible per member:
$0

Annual maximum per member:
Unlimited

Out-of-Pocket (OOP) year maximum per member:
Expenditures for medical, dental, and vision care all contribute to the member's out-of-pocket maximum.

Network:
Advantage Plus 2.0

Service category	Waiting period	Policy pays in-network dentists*	Policy pays out-of-network dentists	After deductible
Diagnostic Services				
Oral Evaluations (Exams)	None	100%	Not Covered	N/A
Radiographs (All X-rays)	None	100%	Not Covered	N/A
Preventive Services				
Prophylaxis (Cleanings)	None	100%	Not Covered	N/A
Fluoride Treatments	None	100%	Not Covered	N/A
Sealants	None	100%	Not Covered	N/A
Space Maintainers	None	100%	Not Covered	N/A
Restorative Services				
Basic Restoration Anterior Composite	None	50%	Not Covered	N/A
Basic Restoration Anterior Amalgam	None	50%	Not Covered	N/A
Basic Restoration Posterior Amalgam	None	50%	Not Covered	N/A
Crowns	None	50%	Not Covered	N/A
Inlays and Onlays	N/A	Not Covered	Not Covered	N/A
Crown Repair	None	50%	Not Covered	N/A
Endodontic Services				
Endodontic Therapy (Root canals, etc.)	None	50%	Not Covered	N/A
Periodontal Services				
Surgical Periodontics	None	50%	Not Covered	N/A
Non-Surgical Periodontics	None	50%	Not Covered	N/A
Periodontal Maintenance	None	50%	Not Covered	N/A
Prosthodontic Services, Fixed				
Prosthetics (Fixed Partial Dentures)	None	50%	Not Covered	N/A

* Pediatric Dental benefits utilize the United Concordia Advantage Provider Network. Members must use a United Concordia provider. There is no out-of-network coverage for this benefit. United Concordia Companies, Inc., is a separate company that administers pediatric dental benefits for Highmark Blue Cross Blue Shield Delaware members.

Service category	Waiting period	Policy pays in-network dentists*	Policy pays out-of-network dentists	After deductible
Prosthodontic Services, Removable				
Prosthetics (Complete Dentures)	None	50%	Not Covered	N/A
Adjustments and Repairs of Prosthetics	None	50%	Not Covered	N/A
Implant Services				
Implant Services	N/A	Not Covered	Not Covered	N/A
Maxillofacial Prosthetics Services				
Maxillofacial Prosthetics	N/A	Not Covered	Not Covered	N/A
Oral and Maxillofacial Surgical Services				
Simple Extractions	None	50%	Not Covered	N/A
Surgical Extractions	None	50%	Not Covered	N/A
Oral Surgery	None	50%	Not Covered	N/A
Apicoectomy/Periradicular Surgery	None	50%	Not Covered	N/A
Adjunctive General Services				
Consultations	None	100%	Not Covered	N/A
General Anesthesia, Nitrous Oxide, and/or IV Sedation	None	50%	Not Covered	N/A
Palliative Treatment (Emergency)	None	100%	Not Covered	N/A
Occlusal Guard	None	50%	Not Covered	N/A
Orthodontic Services				
Medically Necessary Orthodontics	None	50%	Not Covered	N/A
Cosmetic Orthodontic Services	None	Not Covered	Not Covered	N/A

Medically Necessary Orthodontics Coverage

In this section, "Medically Necessary" or "Medical Necessity" means health care services that a physician or dentist would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and are:

1. Generally accepted standards of medical or dental practice.
2. Clinically appropriate, in terms of type, frequency, extent, site, and duration.
3. Considered effective for the patient's illness, injury, or disease.
4. Not primarily for the convenience of the patient, physician, or dentist, and not more costly than another service that is less likely to produce the same results.

As used above, "generally accepted standards of medical or dental practice" means:

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

A Medically Necessary orthodontic service is a procedure that's part of an approved orthodontic plan and is used to treat:

- Severe functional difficulties.
- Birth defects in facial bones and/or oral structures.
- Facial trauma resulting in functional difficulties.
- A psychological/psychiatric diagnosis from a mental health provider.

Coverage of Medically Necessary Orthodontics

1. Orthodontic treatment must be Medically Necessary and be the only method capable of:
   a) Preventing irreversible damage to the insured person's teeth or their supporting structures.
   b) Restoring the insured person's oral structure to health.
2. The insured person must have a full set of permanent teeth to be eligible for Medically Necessary orthodontic services for conditions that severely interfere with oral function.
3. Other orthodontic covered services include:
   - A pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) form, diagnostic photographs, and panoramic radiographs.
   - Limited treatment for the primary, transitional, and adult dentition.
   - Interceptive treatment for the primary transitional dentition.
   - Minor treatment to control harmful habits.
   - Continuation of cases started prior to the insured person's effective date.
   - Orthognathic surgical cases with comprehensive orthodontic treatment.
   - Placement, removal, and repairs of orthodontic appliances.
   - Replacement of a lost or broken retainer.
   - Rebonding or recementing of brackets or bands.
   - Removal of appliances by a provider that did not start the case.
4. **All Medically Necessary orthodontic services require prior approval** and a written plan of care.

2023 Pediatric Dental Coverage Benefit Summary

These benefits apply to High Deductible health plans.

This plan meets the minimum essential health benefit requirements for pediatric oral health as required under the Federal Affordable Care Act.

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

This plan will pay benefits for Covered Services shown below subject to exclusions and other Policy terms. Payment is based on the plan allowance for the specific Covered Service. **Participating Dentists accept contracted plan allowance as payment in full for services.**

Contract year deductible per member:
Expenditures for medical, dental, and vision care all contribute to the member's deductible.

Annual maximum per member:
Unlimited

Out-of-Pocket (OOP) year maximum per member:
Expenditures for medical, dental, and vision care all contribute to the member's out-of-pocket maximum.

Network:
Advantage Plus 2.0

Service category	Waiting period	Policy pays in-network dentists*	Policy pays out-of-network dentists	After deductible
Diagnostic Services				
Oral Evaluations (Exams)	None	100%	Not Covered	No
Radiographs (All X-rays)	None	100%	Not Covered	No
Preventive Services				
Prophylaxis (Cleanings)	None	100%	Not Covered	No
Fluoride Treatments	None	100%	Not Covered	No
Sealants	None	100%	Not Covered	No
Space Maintainers	None	100%	Not Covered	No
Restorative Services				
Basic Restoration Anterior Composite	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Basic Restoration Anterior Amalgam	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Basic Restoration Posterior Amalgam	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Crowns	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Inlays and Onlays	N/A	Not Covered	Not Covered	N/A
Crown Repair	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Endodontic Services				
Endodontic Therapy (Root canals, etc.)	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Periodontal Services				
Surgical Periodontics	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Non-Surgical Periodontics	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Periodontal Maintenance	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Prosthodontic Services, Fixed				
Prosthetics (Fixed Partial Dentures)	None	Coinsurance matches medical coinsurance	Not Covered	Yes

* Pediatric Dental benefits utilize the United Concordia Advantage Provider Network. Members must use a United Concordia provider. There is no out-of-network coverage for this benefit. United Concordia Companies, Inc., is a separate company that administers pediatric dental benefits for Highmark Blue Cross Blue Shield Delaware members.

Service category	Waiting period	Policy pays in-network dentists*	Policy pays out-of-network dentists	After deductible
Prosthodontic Services, Removable				
Prosthetics (Complete Dentures)	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Adjustments and Repairs of Prosthetics	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Implant Services				
Implant Services	N/A	Not Covered	Not Covered	N/A
Maxillofacial Prosthetics Services				
Maxillofacial Prosthetics	N/A	Not Covered	Not Covered	N/A
Oral and Maxillofacial Surgical Services				
Simple Extractions	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Surgical Extractions	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Oral Surgery	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Apicoectomy/Periradicular Surgery	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Adjunctive General Services				
Consultations	None	Coinsurance matches medical coinsurance	Not Covered	Yes
General Anesthesia, Nitrous Oxide, and/or IV Sedation	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Palliative Treatment (Emergency)	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Occlusal Guard	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Orthodontic Services				
Medically Necessary Orthodontics	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Cosmetic Orthodontic Services	None	Not Covered	Not Covered	N/A

Medically Necessary Orthodontics Coverage

In this section, "Medically Necessary" or "Medical Necessity" means health care services that a physician or dentist would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and are:

1. Generally accepted standards of medical or dental practice.
2. Clinically appropriate, in terms of type, frequency, extent, site, and duration.
3. Considered effective for the patient's illness, injury, or disease.
4. Not primarily for the convenience of the patient, physician, or dentist, and not more costly than another service that is less likely to produce the same results.

As used above, "generally accepted standards of medical or dental practice" means:

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

A Medically Necessary orthodontic service is a procedure that's part of an approved orthodontic plan and is used to treat:

- Severe functional difficulties.
- Birth defects in facial bones and/or oral structures.
- Facial trauma resulting in functional difficulties.
- A psychological/psychiatric diagnosis from a mental health provider.

Coverage of Medically Necessary Orthodontics

1. Orthodontic treatment must be Medically Necessary and be the only method capable of:
   a) Preventing irreversible damage to the insured person's teeth or their supporting structures.
   b) Restoring the insured person's oral structure to health.
2. The insured person must have a full set of permanent teeth to be eligible for Medically Necessary orthodontic services for conditions that severely interfere with oral function.
3. Other orthodontic covered services include:
   - A pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) form, diagnostic photographs, and panoramic radiographs.
   - Limited treatment for the primary, transitional, and adult dentition.
   - Interceptive treatment for the primary transitional dentition.
   - Minor treatment to control harmful habits.
   - Continuation of cases started prior to the insured person's effective date.
   - Orthognathic surgical cases with comprehensive orthodontic treatment.
   - Placement, removal, and repairs of orthodontic appliances.
   - Replacement of a lost or broken retainer.
   - Rebonding or recementing of brackets or bands.
   - Removal of appliances by a provider that did not start the case.
4. **All Medically Necessary orthodontic services require prior approval** and a written plan of care.

2023 Pediatric Dental Coverage Benefit Summary

These benefits apply to Catastrophic health plans.

This plan meets the minimum essential health benefit requirements for pediatric oral health as required under the Federal Affordable Care Act.

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

This plan will pay benefits for Covered Services shown below subject to exclusions and other Policy terms. Payment is based on the plan allowance for the specific Covered Service. **Participating Dentists accept contracted plan allowance as payment in full for services.**

Contract year deductible per member:
Expenditures for medical, dental, and vision care all contribute to the member's deductible.

Annual maximum per member:
Unlimited

Out-of-Pocket (OOP) year maximum per member:
Expenditures for medical, dental, and vision care all contribute to the member's out-of-pocket maximum.

Network:
Advantage

Service category	Waiting period	Policy pays in-network dentists*	Policy pays out-of-network dentists	After deductible
Diagnostic Services				
Oral Evaluations (Exams)	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Radiographs (All X-rays)	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Preventive Services				
Prophylaxis (Cleanings)	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Fluoride Treatments	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Sealants	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Space Maintainers	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Restorative Services				
Basic Restoration Anterior Composite	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Basic Restoration Anterior Amalgam	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Basic Restoration Posterior Amalgam	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Crowns	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Inlays and Onlays	None	Coinsurance matches medical coinsurance	Not Covered	N/A
Crown Repair	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Endodontic Services				
Endodontic Therapy (Root canals, etc.)	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Periodontal Services				
Surgical Periodontics	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Non-Surgical Periodontics	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Periodontal Maintenance	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Prosthodontic Services, Fixed				
Prosthetics (Fixed Partial Dentures)	None	Coinsurance matches medical coinsurance	Not Covered	Yes

* Pediatric Dental benefits utilize the United Concordia Advantage Provider Network. Members must use a United Concordia provider. There is no out-of-network coverage for this benefit. United Concordia Companies, Inc., is a separate company that administers pediatric dental benefits for Highmark Blue Cross Blue Shield Delaware members.

Service category	Waiting period	Policy pays in-network dentists*	Policy pays out-of-network dentists	After deductible
Prosthodontic Services, Removable				
Prosthetics (Complete Dentures)	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Adjustments and Repairs of Prosthetics	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Implant Services				
Implant Services	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Maxillofacial Prosthetics Services				
Maxillofacial Prosthetics	N/A	Not Covered	Not Covered	N/A
Oral and Maxillofacial Surgical Services				
Simple Extractions	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Surgical Extractions	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Oral Surgery	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Apicoectomy/Periradicular Surgery	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Adjunctive General Services				
Consultations	None	Coinsurance matches medical coinsurance	Not Covered	Yes
General Anesthesia, Nitrous Oxide, and/or IV Sedation	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Palliative Treatment (Emergency)	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Occlusal Guard	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Orthodontic Services				
Medically Necessary Orthodontics	None	Coinsurance matches medical coinsurance	Not Covered	Yes
Cosmetic Orthodontic Services	None	Not Covered	Not Covered	N/A

Medically Necessary Orthodontics Coverage

In this section, "Medically Necessary" or "Medical Necessity" means health care services that a physician or dentist would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and are:

1. Generally accepted standards of medical or dental practice.
2. Clinically appropriate, in terms of type, frequency, extent, site, and duration.
3. Considered effective for the patient's illness, injury, or disease.
4. Not primarily for the convenience of the patient, physician, or dentist, and not more costly than another service that is less likely to produce the same results.

As used above, "generally accepted standards of medical or dental practice" means:

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

A Medically Necessary orthodontic service is a procedure that's part of an approved orthodontic plan and is used to treat:

- Severe functional difficulties.
- Birth defects in facial bones and/or oral structures.
- Facial trauma resulting in functional difficulties.
- A psychological/psychiatric diagnosis from a mental health provider.

Coverage of Medically Necessary Orthodontics

1. Orthodontic treatment must be Medically Necessary and be the only method capable of:
   a) Preventing irreversible damage to the insured person's teeth or their supporting structures.
   b) Restoring the insured person's oral structure to health.
2. The insured person must have a full set of permanent teeth to be eligible for Medically Necessary orthodontic services for conditions that severely interfere with oral function.
3. Other orthodontic covered services include:
   - A pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) form, diagnostic photographs, and panoramic radiographs.
   - Limited treatment for the primary, transitional, and adult dentition.
   - Interceptive treatment for the primary transitional dentition.
   - Minor treatment to control harmful habits.
   - Continuation of cases started prior to the insured person's effective date.
   - Orthognathic surgical cases with comprehensive orthodontic treatment.
   - •Placement, removal, and repairs of orthodontic appliances.
   - Replacement of a lost or broken retainer.
   - Rebonding or recementing of brackets or bands.
   - Removal of appliances by a provider that did not start the case.
4. **All Medically Necessary orthodontic services require prior approval** and a written plan of care.

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross Blue Shield Association.

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 2023.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to highmark.com/zipcode-gate-login; or for a paper copy, call 1-855-329-0694.

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

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.

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

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

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

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 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.

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

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 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.

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

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 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 .

HIGHMARK. DELAWARE

Because Life.™

Monthly Premium Rates

For Benefit Period:
January 1 to December 31, 2023

HIGHMARK DELAWARE

Here's how to calculate your monthly premium.

By this point, you know the Highmark plan you want. The grids in the following section will help you know what your total monthly premium should add up to.

Who to include in your calculation:

– Yourself

– Your spouse or partner who will be covered

– All children between ages 21 and 26 who will be covered

– The three oldest children under age 21 who will be covered

– Any additional family members who will be covered

If you're going to have more than three children under 21 on your plan, only include premiums for the oldest three below when calculating your total monthly premium. Your policy will cover any additional younger children; just be sure to list all of them as dependents when you enroll.

Fill in the chart below to calculate your total monthly premium.

Highmark Plan Name: _____

	Name	Age	Tobacco user? (yes or no)	Premium amount (from chart)
You				
Your spouse or partner				
Children between ages 21 and 26				
Children under 21				
Additional family members				
			Total =	

If you need help filling out your enrollment application, call 855-882-6533.

Premium Rates

Use the Marketplace Plan ID to find your plan on the Federal Marketplace.

If you are purchasing a plan directly through Highmark, use the Non-Marketplace Plan ID.

Age	Catastrophic		Bronze		Bronze		Bronze	
	my Blue Access Major Events PPO Catastrophic 9100 - 3 Free PCP Visits		my Blue Access PPO Standard Bronze 9100		my Blue Access PPO Bronze 6900 HSA - Custom Drug Benefit		my Blue Access PPO Bronze 3800	
	Marketplace Plan ID: 76168DE0720001		Marketplace Plan ID: 76168DE0760001		Marketplace Plan ID: 76168DE0710001		Marketplace Plan ID: 76168DE0690001	
	Non-Marketplace Plan ID: 76168DE0720001		Non-Marketplace Plan ID: 76168DE0760001		Non-Marketplace Plan ID: 76168DE0710001		Non-Marketplace Plan ID: 76168DE0690001	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0-14	$190.88	$190.88	$241.34	$241.34	$266.76	$266.76	$260.09	$260.09
15	$207.85	$207.85	$262.79	$262.79	$290.48	$290.48	$283.21	$283.21
16	$214.34	$214.34	$271.00	$271.00	$299.54	$299.54	$292.05	$292.05
17	$220.83	$220.83	$279.20	$279.20	$308.61	$308.61	$300.89	$300.89
18	$227.81	$227.81	$288.03	$288.03	$318.37	$318.37	$310.41	$310.41
19	$234.80	$234.80	$296.87	$296.87	$328.14	$328.14	$319.93	$319.93
20	$242.03	$242.03	$306.02	$306.02	$338.25	$338.25	$329.79	$329.79
21	$249.52	$255.76	$315.48	$323.37	$348.71	$357.43	$339.99	$348.49
22	$249.52	$255.76	$315.48	$323.37	$348.71	$357.43	$339.99	$348.49
23	$249.52	$255.76	$315.48	$323.37	$348.71	$357.43	$339.99	$348.49
24	$249.52	$255.76	$315.48	$323.37	$348.71	$357.43	$339.99	$348.49
25	$250.52	$256.78	$316.74	$324.66	$350.10	$358.85	$341.35	$349.88
26	$255.51	$261.90	$323.05	$331.13	$357.08	$366.01	$348.15	$356.85
27	$261.50	$268.04	$330.62	$338.89	$365.45	$374.59	$356.31	$365.22
28	$271.23	$278.01	$342.93	$351.50	$379.05	$388.53	$369.57	$378.81
29	$279.21	$286.19	$353.02	$361.85	$390.21	$399.97	$380.45	$389.96
30	$283.21	$290.29	$358.07	$367.02	$395.79	$405.68	$385.89	$395.54
31	$289.19	$296.42	$365.64	$374.78	$404.15	$414.25	$394.05	$403.90
32	$295.18	$302.56	$373.21	$382.54	$412.52	$422.83	$402.21	$412.27
33	$298.92	$306.39	$377.95	$387.40	$417.75	$428.19	$407.31	$417.49
34	$302.92	$310.49	$382.99	$392.56	$423.33	$433.91	$412.75	$423.07
35	$304.91	$312.53	$385.52	$395.16	$426.12	$436.77	$415.47	$425.86
36	$306.91	$314.58	$388.04	$397.74	$428.91	$439.63	$418.19	$428.64
37	$308.91	$316.63	$390.56	$400.32	$431.70	$442.49	$420.91	$431.43
38	$310.90	$318.67	$393.09	$402.92	$434.49	$445.35	$423.63	$434.22
39	$314.89	$322.76	$398.14	$408.09	$440.07	$451.07	$429.07	$439.80
40	$318.89	$350.78	$403.18	$443.50	$445.65	$490.22	$434.51	$477.96
41	$324.88	$358.99	$410.75	$453.88	$454.02	$501.69	$442.67	$489.15
42	$330.61	$367.64	$418.01	$464.83	$462.04	$513.79	$450.49	$500.94
43	$338.60	$379.57	$428.11	$479.91	$473.20	$530.46	$461.37	$517.20
44	$348.58	$394.59	$440.73	$498.91	$487.15	$551.45	$474.97	$537.67
45	$360.31	$412.55	$455.55	$521.60	$503.54	$576.55	$490.95	$562.14
46	$374.28	$434.16	$473.22	$548.94	$523.07	$606.76	$509.99	$591.59
47	$390.00	$459.03	$493.10	$580.38	$545.03	$641.50	$531.40	$625.46
48	$407.97	$487.93	$515.81	$616.91	$570.14	$681.89	$555.88	$664.83
49	$425.68	$518.05	$538.21	$655.00	$594.90	$723.99	$580.02	$705.88
50	$445.64	$545.91	$563.45	$690.23	$622.80	$762.93	$607.22	$743.84
51	$465.35	$570.05	$588.37	$720.75	$650.34	$796.67	$634.08	$776.75
52	$487.06	$596.65	$615.82	$754.38	$680.68	$833.83	$663.66	$812.98
53	$509.02	$623.55	$643.58	$788.39	$711.37	$871.43	$693.58	$849.64
54	$532.73	$652.59	$673.55	$825.10	$744.50	$912.01	$725.88	$889.20
55	$556.43	$681.63	$703.52	$861.81	$777.62	$952.58	$758.18	$928.77
56	$582.13	$713.11	$736.01	$901.61	$813.54	$996.59	$793.20	$971.67
57	$608.08	$744.90	$768.82	$941.80	$849.81	$1,041.02	$828.56	$1,014.99
58	$635.78	$778.83	$803.84	$984.70	$888.51	$1,088.42	$866.29	$1,061.21
59	$649.50	$795.64	$821.19	$1,005.96	$907.69	$1,111.92	$884.99	$1,084.11
60	$677.20	$829.57	$856.21	$1,048.86	$946.40	$1,159.34	$922.73	$1,130.34
61	$701.15	$858.91	$886.50	$1,085.96	$979.88	$1,200.35	$955.37	$1,170.33
62	$716.87	$878.17	$906.37	$1,110.30	$1,001.84	$1,227.25	$976.79	$1,196.57
63	$736.58	$902.31	$931.30	$1,140.84	$1,029.39	$1,261.00	$1,003.65	$1,229.47
64+	$748.56	$916.99	$946.44	$1,159.39	$1,046.13	$1,281.51	$1,019.97	$1,249.46

Premium Rates

Use the Marketplace Plan ID to find your plan on the Federal Marketplace.

If you are purchasing a plan directly through Highmark, use the Non-Marketplace Plan ID.

Age	Bronze		Silver		Silver		Silver	
	my Blue Access PPO Bronze 3800 + Adult Dental and Vision		my Blue Access PPO Silver 5900		my Blue Access PPO Standard Silver 5800		my Blue Access PPO Standard Silver 5800 + Adult Dental and Vision	
	Marketplace Plan ID: 76168DE0700001		Marketplace Plan ID: 76168DE0690007		Marketplace Plan ID: 76168DE0760002		Marketplace Plan ID: 76168DE0770001	
	Non-Marketplace Plan ID: 76168DE0700001		Non-Marketplace Plan ID: 76168DE0690007		Non-Marketplace Plan ID: 76168DE0760002		Non-Marketplace Plan ID: 76168DE0770001	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0-14	$278.92	$278.92	$331.14	$331.14	$333.01	$333.01	$351.84	$351.84
15	$303.71	$303.71	$360.57	$360.57	$362.61	$362.61	$383.11	$383.11
16	$313.19	$313.19	$371.83	$371.83	$373.93	$373.93	$395.07	$395.07
17	$322.67	$322.67	$383.08	$383.08	$385.25	$385.25	$407.03	$407.03
18	$332.88	$332.88	$395.20	$395.20	$397.44	$397.44	$419.91	$419.91
19	$343.09	$343.09	$407.32	$407.32	$409.63	$409.63	$432.78	$432.78
20	$353.66	$353.66	$419.87	$419.87	$422.25	$422.25	$446.12	$446.12
21	$364.60	$373.72	$432.86	$443.68	$435.31	$446.19	$459.92	$471.42
22	$364.60	$373.72	$432.86	$443.68	$435.31	$446.19	$459.92	$471.42
23	$364.60	$373.72	$432.86	$443.68	$435.31	$446.19	$459.92	$471.42
24	$364.60	$373.72	$432.86	$443.68	$435.31	$446.19	$459.92	$471.42
25	$366.06	$375.21	$434.59	$445.45	$437.05	$447.98	$461.76	$473.30
26	$373.35	$382.68	$443.25	$454.33	$445.76	$456.90	$470.96	$482.73
27	$382.10	$391.65	$453.64	$464.98	$456.20	$467.61	$482.00	$494.05
28	$396.32	$406.23	$470.52	$482.28	$473.18	$485.01	$499.93	$512.43
29	$407.99	$418.19	$484.37	$496.48	$487.11	$499.29	$514.65	$527.52
30	$413.82	$424.17	$491.30	$503.58	$494.08	$506.43	$522.01	$535.06
31	$422.57	$433.13	$501.68	$514.22	$504.52	$517.13	$533.05	$546.38
32	$431.32	$442.10	$512.07	$524.87	$514.97	$527.84	$544.09	$557.69
33	$436.79	$447.71	$518.57	$531.53	$521.50	$534.54	$550.98	$564.75
34	$442.62	$453.69	$525.49	$538.63	$528.47	$541.68	$558.34	$572.30
35	$445.54	$456.68	$528.95	$542.17	$531.95	$545.25	$562.02	$576.07
36	$448.46	$459.67	$532.42	$545.73	$535.43	$548.82	$565.70	$579.84
37	$451.37	$462.65	$535.88	$549.28	$538.91	$552.38	$569.38	$583.61
38	$454.29	$465.65	$539.34	$552.82	$542.40	$555.96	$573.06	$587.39
39	$460.13	$471.63	$546.27	$559.93	$549.36	$563.09	$580.42	$594.93
40	$465.96	$512.56	$553.20	$608.52	$556.33	$611.96	$587.78	$646.56
41	$474.71	$524.55	$563.58	$622.76	$566.77	$626.28	$598.82	$661.70
42	$483.10	$537.21	$573.54	$637.78	$576.79	$641.39	$609.39	$677.64
43	$494.76	$554.63	$587.39	$658.46	$590.72	$662.20	$624.11	$699.63
44	$509.35	$576.58	$604.71	$684.53	$608.13	$688.40	$642.51	$727.32
45	$526.48	$602.82	$625.05	$715.68	$628.59	$719.74	$664.12	$760.42
46	$546.90	$634.40	$649.29	$753.18	$652.97	$757.45	$689.88	$800.26
47	$569.87	$670.74	$676.56	$796.31	$680.39	$800.82	$718.85	$846.09
48	$596.12	$712.96	$707.73	$846.45	$711.73	$851.23	$751.97	$899.36
49	$622.01	$756.99	$738.46	$898.71	$742.64	$903.79	$784.62	$954.88
50	$651.18	$797.70	$773.09	$947.04	$777.46	$952.39	$821.42	$1,006.24
51	$679.98	$832.98	$807.28	$988.92	$811.85	$994.52	$857.75	$1,050.74
52	$711.70	$871.83	$844.94	$1,035.05	$849.73	$1,040.92	$897.76	$1,099.76
53	$743.78	$911.13	$883.03	$1,081.71	$888.03	$1,087.84	$938.24	$1,149.34
54	$778.42	$953.56	$924.16	$1,132.10	$929.39	$1,138.50	$981.93	$1,202.86
55	$813.06	$996.00	$965.28	$1,182.47	$970.74	$1,189.16	$1,025.62	$1,256.38
56	$850.61	$1,042.00	$1,009.86	$1,237.08	$1,015.58	$1,244.09	$1,072.99	$1,314.41
57	$888.53	$1,088.45	$1,054.88	$1,292.23	$1,060.85	$1,299.54	$1,120.83	$1,373.02
58	$929.00	$1,138.03	$1,102.93	$1,351.09	$1,109.17	$1,358.73	$1,171.88	$1,435.55
59	$949.05	$1,162.59	$1,126.73	$1,380.24	$1,133.11	$1,388.06	$1,197.17	$1,466.53
60	$989.52	$1,212.16	$1,174.78	$1,439.11	$1,181.43	$1,447.25	$1,248.22	$1,529.07
61	$1,024.53	$1,255.05	$1,216.34	$1,490.02	$1,223.22	$1,498.44	$1,292.38	$1,583.17
62	$1,047.50	$1,283.19	$1,243.61	$1,523.42	$1,250.65	$1,532.05	$1,321.35	$1,618.65
63	$1,076.30	$1,318.47	$1,277.80	$1,565.31	$1,285.04	$1,574.17	$1,357.68	$1,663.16
64+	$1,093.80	$1,339.91	$1,298.58	$1,590.76	$1,305.93	$1,599.76	$1,379.76	$1,690.21

Premium Rates

Use the Marketplace Plan ID to find your plan on the Federal Marketplace.

If you are purchasing a plan directly through Highmark, use the Non-Marketplace Plan ID.

Age	Silver		Silver		Gold		Gold	
	my Blue Access PPO Silver 3500		my Blue Access PPO Silver 3500 + Adult Dental and Vision		my Blue Access PPO Gold 1700 HSA		my Blue Access PPO Standard Gold 2000	
	Marketplace Plan ID: N/A		Marketplace Plan ID: N/A		Marketplace Plan ID: 76168DE0710003		Marketplace Plan ID: 76168DE0760003	
	Non-Marketplace Plan ID: 76168DE0690003		Non-Marketplace Plan ID: 76168DE0700003		Non-Marketplace Plan ID: 76168DE0710003		Non-Marketplace Plan ID: 76168DE0760003	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0-14	$284.68	$284.68	$303.51	$303.51	$319.88	$319.88	$316.14	$316.14
15	$309.98	$309.98	$330.48	$330.48	$348.31	$348.31	$344.24	$344.24
16	$319.66	$319.66	$340.80	$340.80	$359.18	$359.18	$354.98	$354.98
17	$329.34	$329.34	$351.11	$351.11	$370.05	$370.05	$365.73	$365.73
18	$339.75	$339.75	$362.22	$362.22	$381.76	$381.76	$377.30	$377.30
19	$350.17	$350.17	$373.33	$373.33	$393.47	$393.47	$388.87	$388.87
20	$360.97	$360.97	$384.84	$384.84	$405.60	$405.60	$400.85	$400.85
21	$372.13	$381.43	$396.74	$406.66	$418.14	$428.59	$413.25	$423.58
22	$372.13	$381.43	$396.74	$406.66	$418.14	$428.59	$413.25	$423.58
23	$372.13	$381.43	$396.74	$406.66	$418.14	$428.59	$413.25	$423.58
24	$372.13	$381.43	$396.74	$406.66	$418.14	$428.59	$413.25	$423.58
25	$373.62	$382.96	$398.33	$408.29	$419.81	$430.31	$414.90	$425.27
26	$381.06	$390.59	$406.26	$416.42	$428.18	$438.88	$423.17	$433.75
27	$389.99	$399.74	$415.78	$426.17	$438.21	$449.17	$433.09	$443.92
28	$404.51	$414.62	$431.26	$442.04	$454.52	$465.88	$449.20	$460.43
29	$416.41	$426.82	$443.95	$455.05	$467.90	$479.60	$462.43	$473.99
30	$422.37	$432.93	$450.30	$461.56	$474.59	$486.45	$469.04	$480.77
31	$431.30	$442.08	$459.82	$471.32	$484.62	$496.74	$478.96	$490.93
32	$440.23	$451.24	$469.34	$481.07	$494.66	$507.03	$488.87	$501.09
33	$445.81	$456.96	$475.29	$487.17	$500.93	$513.45	$495.07	$507.45
34	$451.77	$463.06	$481.64	$493.68	$507.62	$520.31	$501.69	$514.23
35	$454.74	$466.11	$484.82	$496.94	$510.97	$523.74	$504.99	$517.61
36	$457.72	$469.16	$487.99	$500.19	$514.31	$527.17	$508.30	$521.01
37	$460.70	$472.22	$491.16	$503.44	$517.66	$530.60	$511.60	$524.39
38	$463.67	$475.26	$494.34	$506.70	$521.00	$534.03	$514.91	$527.78
39	$469.63	$481.37	$500.69	$513.21	$527.69	$540.88	$521.52	$534.56
40	$475.58	$523.14	$507.03	$557.73	$534.38	$587.82	$528.13	$580.94
41	$484.51	$535.38	$516.56	$570.80	$544.42	$601.58	$538.05	$594.55
42	$493.07	$548.29	$525.68	$584.56	$554.04	$616.09	$547.56	$608.89
43	$504.98	$566.08	$538.38	$603.52	$567.42	$636.08	$560.78	$628.63
44	$519.87	$588.49	$554.25	$627.41	$584.14	$661.25	$577.31	$653.51
45	$537.36	$615.28	$572.89	$655.96	$603.79	$691.34	$596.73	$683.26
46	$558.20	$647.51	$595.11	$690.33	$627.21	$727.56	$619.88	$719.06
47	$581.64	$684.59	$620.10	$729.86	$653.55	$769.23	$645.91	$760.24
48	$608.43	$727.68	$648.67	$775.81	$683.66	$817.66	$675.66	$808.09
49	$634.85	$772.61	$676.84	$823.71	$713.35	$868.15	$705.00	$857.98
50	$664.62	$814.16	$708.58	$868.01	$746.80	$914.83	$738.06	$904.12
51	$694.02	$850.17	$739.92	$906.40	$779.83	$955.29	$770.71	$944.12
52	$726.40	$889.84	$774.44	$948.69	$816.21	$999.86	$806.66	$988.16
53	$759.15	$929.96	$809.35	$991.45	$853.01	$1,044.94	$843.03	$1,032.71
54	$794.50	$973.26	$847.04	$1,037.62	$892.73	$1,093.59	$882.29	$1,080.81
55	$829.85	$1,016.57	$884.73	$1,083.79	$932.45	$1,142.25	$921.55	$1,128.90
56	$868.18	$1,063.52	$925.59	$1,133.85	$975.52	$1,195.01	$964.11	$1,181.03
57	$906.88	$1,110.93	$966.86	$1,184.40	$1,019.01	$1,248.29	$1,007.09	$1,233.69
58	$948.19	$1,161.53	$1,010.89	$1,238.34	$1,065.42	$1,305.14	$1,052.96	$1,289.88
59	$968.65	$1,186.60	$1,032.71	$1,265.07	$1,088.42	$1,333.31	$1,075.69	$1,317.72
60	$1,009.96	$1,237.20	$1,076.75	$1,319.02	$1,134.83	$1,390.17	$1,121.56	$1,373.91
61	$1,045.69	$1,280.97	$1,114.84	$1,365.68	$1,174.97	$1,439.34	$1,161.23	$1,422.51
62	$1,069.13	$1,309.68	$1,139.83	$1,396.29	$1,201.32	$1,471.62	$1,187.27	$1,454.41
63	$1,098.53	$1,345.70	$1,171.18	$1,434.70	$1,234.35	$1,512.08	$1,219.91	$1,494.39
64+	$1,116.39	$1,367.58	$1,190.22	$1,458.02	$1,254.42	$1,536.66	$1,239.75	$1,518.69

Premium Rates

Use the Marketplace Plan ID to find your plan on the Federal Marketplace.

If you are purchasing a plan directly through Highmark, use the Non-Marketplace Plan ID.

Age	Gold		Gold		Gold		Gold	
	my Blue Access PPO Gold 0		my Blue Access PPO Gold 0 + Adult Dental and Vision		my Blue Access PPO Premier Gold 0		my Blue Access PPO Premier Gold 0 + Adult Dental and Vision	
	Marketplace Plan ID: 76168DE0690004		Marketplace Plan ID: 76168DE0700004		Marketplace Plan ID: 76168DE0730001		Marketplace Plan ID: 76168DE0740002	
	Non-Marketplace Plan ID: 76168DE0690004		Non-Marketplace Plan ID: 76168DE0700004		Non-Marketplace Plan ID: 76168DE0730001		Non-Marketplace Plan ID: 76168DE0740002	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0-14	$333.31	$333.31	$352.14	$352.14	$345.89	$345.89	$364.71	$364.71
15	$362.94	$362.94	$383.44	$383.44	$376.63	$376.63	$397.12	$397.12
16	$374.27	$374.27	$395.41	$395.41	$388.39	$388.39	$409.52	$409.52
17	$385.59	$385.59	$407.37	$407.37	$400.14	$400.14	$421.91	$421.91
18	$397.79	$397.79	$420.26	$420.26	$412.80	$412.80	$435.26	$435.26
19	$409.99	$409.99	$433.15	$433.15	$425.46	$425.46	$448.61	$448.61
20	$422.63	$422.63	$446.50	$446.50	$438.58	$438.58	$462.44	$462.44
21	$435.70	$446.59	$460.31	$471.82	$452.14	$463.44	$476.74	$488.66
22	$435.70	$446.59	$460.31	$471.82	$452.14	$463.44	$476.74	$488.66
23	$435.70	$446.59	$460.31	$471.82	$452.14	$463.44	$476.74	$488.66
24	$435.70	$446.59	$460.31	$471.82	$452.14	$463.44	$476.74	$488.66
25	$437.44	$448.38	$462.15	$473.70	$453.95	$465.30	$478.65	$490.62
26	$446.16	$457.31	$471.36	$483.14	$462.99	$474.56	$488.18	$500.38
27	$456.61	$468.03	$482.40	$494.46	$473.84	$485.69	$499.62	$512.11
28	$473.61	$485.45	$500.36	$512.87	$491.48	$503.77	$518.22	$531.18
29	$487.55	$499.74	$515.09	$527.97	$505.94	$518.59	$533.47	$546.81
30	$494.52	$506.88	$522.45	$535.51	$513.18	$526.01	$541.10	$554.63
31	$504.98	$517.60	$533.50	$546.84	$524.03	$537.13	$552.54	$566.35
32	$515.43	$528.32	$544.55	$558.16	$534.88	$548.25	$563.98	$578.08
33	$521.97	$535.02	$551.45	$565.24	$541.66	$555.20	$571.13	$585.41
34	$528.94	$542.16	$558.82	$572.79	$548.90	$562.62	$578.76	$593.23
35	$532.43	$545.74	$562.50	$576.56	$552.52	$566.33	$582.58	$597.14
36	$535.91	$549.31	$566.18	$580.33	$556.13	$570.03	$586.39	$601.05
37	$539.40	$552.89	$569.86	$584.11	$559.75	$573.74	$590.20	$604.96
38	$542.88	$556.45	$573.55	$587.89	$563.37	$577.45	$594.02	$608.87
39	$549.85	$563.60	$580.91	$595.43	$570.60	$584.87	$601.65	$616.69
40	$556.82	$612.50	$588.28	$647.11	$577.83	$635.61	$609.27	$670.20
41	$567.28	$626.84	$599.32	$662.25	$588.69	$650.50	$620.72	$685.90
42	$577.30	$641.96	$609.91	$678.22	$599.09	$666.19	$631.68	$702.43
43	$591.24	$662.78	$624.64	$700.22	$613.55	$687.79	$646.94	$725.22
44	$608.67	$689.01	$643.05	$727.93	$631.64	$715.02	$666.01	$753.92
45	$629.15	$720.38	$664.69	$761.07	$652.89	$747.56	$688.41	$788.23
46	$653.55	$758.12	$690.47	$800.95	$678.21	$786.72	$715.11	$829.53
47	$681.00	$801.54	$719.46	$846.80	$706.69	$831.77	$745.14	$877.03
48	$712.37	$851.99	$752.61	$900.12	$739.25	$884.14	$779.47	$932.25
49	$743.30	$904.60	$785.29	$955.70	$771.35	$938.73	$813.32	$989.81
50	$778.16	$953.25	$822.11	$1,007.08	$807.52	$989.21	$851.46	$1,043.04
51	$812.58	$995.41	$858.48	$1,051.64	$843.24	$1,032.97	$889.12	$1,089.17
52	$850.49	$1,041.85	$898.53	$1,100.70	$882.58	$1,081.16	$930.60	$1,139.99
53	$888.83	$1,088.82	$939.03	$1,150.31	$922.37	$1,129.90	$972.55	$1,191.37
54	$930.22	$1,139.52	$982.76	$1,203.88	$965.32	$1,182.52	$1,017.84	$1,246.85
55	$971.61	$1,190.22	$1,026.49	$1,257.45	$1,008.27	$1,235.13	$1,063.13	$1,302.33
56	$1,016.49	$1,245.20	$1,073.90	$1,315.53	$1,054.84	$1,292.18	$1,112.23	$1,362.48
57	$1,061.80	$1,300.71	$1,121.78	$1,374.18	$1,101.87	$1,349.79	$1,161.82	$1,423.23
58	$1,110.16	$1,359.95	$1,172.87	$1,436.77	$1,152.05	$1,411.26	$1,214.73	$1,488.04
59	$1,134.13	$1,389.31	$1,198.19	$1,467.78	$1,176.92	$1,441.73	$1,240.95	$1,520.16
60	$1,182.49	$1,448.55	$1,249.28	$1,530.37	$1,227.11	$1,503.21	$1,293.87	$1,584.99
61	$1,224.32	$1,499.79	$1,293.47	$1,584.50	$1,270.51	$1,556.37	$1,339.64	$1,641.06
62	$1,251.77	$1,533.42	$1,322.47	$1,620.03	$1,299.00	$1,591.28	$1,369.67	$1,677.85
63	$1,286.19	$1,575.58	$1,358.84	$1,664.58	$1,334.72	$1,635.03	$1,407.34	$1,723.99
64+	$1,307.10	$1,601.20	$1,380.93	$1,691.64	$1,356.42	$1,661.61	$1,430.22	$1,752.02

Premium Rates

Use the Marketplace Plan ID to find your plan on the Federal Marketplace.

If you are purchasing a plan directly through Highmark, use the Non-Marketplace Plan ID.

Age	Platinum		Platinum		Platinum	
	my Blue Access PPO Standard Platinum 0		my Blue Access PPO Platinum 0		my Blue Access PPO Platinum 0 + Adult Dental and Vision	
	Marketplace Plan ID: 76168DE0760004		Marketplace Plan ID: 76168DE0690005		Marketplace Plan ID: 76168DE0700005	
	Non-Marketplace Plan ID: 76168DE0760004		Non-Marketplace Plan ID: 76168DE0690005		Non-Marketplace Plan ID: 76168DE0700005	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0-14	$473.06	$473.06	$450.81	$450.81	$469.63	$469.63
15	$515.11	$515.11	$490.89	$490.89	$511.38	$511.38
16	$531.19	$531.19	$506.21	$506.21	$527.34	$527.34
17	$547.27	$547.27	$521.53	$521.53	$543.30	$543.30
18	$564.58	$564.58	$538.03	$538.03	$560.49	$560.49
19	$581.90	$581.90	$554.53	$554.53	$577.68	$577.68
20	$599.83	$599.83	$571.62	$571.62	$595.48	$595.48
21	$618.38	$633.84	$589.30	$604.03	$613.90	$629.25
22	$618.38	$633.84	$589.30	$604.03	$613.90	$629.25
23	$618.38	$633.84	$589.30	$604.03	$613.90	$629.25
24	$618.38	$633.84	$589.30	$604.03	$613.90	$629.25
25	$620.85	$636.37	$591.66	$606.45	$616.36	$631.77
26	$633.22	$649.05	$603.44	$618.53	$628.63	$644.35
27	$648.06	$664.26	$617.59	$633.03	$643.37	$659.45
28	$672.18	$688.98	$640.57	$656.58	$667.31	$683.99
29	$691.97	$709.27	$659.43	$675.92	$686.95	$704.12
30	$701.86	$719.41	$668.86	$685.58	$696.78	$714.20
31	$716.70	$734.62	$683.00	$700.08	$711.51	$729.30
32	$731.54	$749.83	$697.14	$714.57	$726.24	$744.40
33	$740.82	$759.34	$705.98	$723.63	$735.45	$753.84
34	$750.71	$769.48	$715.41	$733.30	$745.27	$763.90
35	$755.66	$774.55	$720.12	$738.12	$750.19	$768.94
36	$760.61	$779.63	$724.84	$742.96	$755.10	$773.98
37	$765.55	$784.69	$729.55	$747.79	$760.01	$779.01
38	$770.50	$789.76	$734.27	$752.63	$764.92	$784.04
39	$780.40	$799.91	$743.70	$762.29	$774.74	$794.11
40	$790.29	$869.32	$753.13	$828.44	$784.56	$863.02
41	$805.13	$889.67	$767.27	$847.83	$799.30	$883.23
42	$819.35	$911.12	$780.82	$868.27	$813.42	$904.52
43	$839.14	$940.68	$799.68	$896.44	$833.06	$933.86
44	$863.88	$977.91	$823.25	$931.92	$857.62	$970.83
45	$892.94	$1,022.42	$850.95	$974.34	$886.47	$1,015.01
46	$927.57	$1,075.98	$883.95	$1,025.38	$920.85	$1,068.19
47	$966.53	$1,137.61	$921.08	$1,084.11	$959.53	$1,129.37
48	$1,011.05	$1,209.22	$963.51	$1,152.36	$1,003.73	$1,200.46
49	$1,054.96	$1,283.89	$1,005.35	$1,223.51	$1,047.31	$1,274.58
50	$1,104.43	$1,352.93	$1,052.49	$1,289.30	$1,096.43	$1,343.13
51	$1,153.28	$1,412.77	$1,099.04	$1,346.32	$1,144.92	$1,402.53
52	$1,207.08	$1,478.67	$1,150.31	$1,409.13	$1,198.33	$1,467.95
53	$1,261.50	$1,545.34	$1,202.17	$1,472.66	$1,252.36	$1,534.14
54	$1,320.24	$1,617.29	$1,258.16	$1,541.25	$1,310.68	$1,605.58
55	$1,378.99	$1,689.26	$1,314.14	$1,609.82	$1,369.00	$1,677.03
56	$1,442.68	$1,767.28	$1,374.84	$1,684.18	$1,432.23	$1,754.48
57	$1,506.99	$1,846.06	$1,436.12	$1,759.25	$1,496.07	$1,832.69
58	$1,575.63	$1,930.15	$1,501.54	$1,839.39	$1,564.22	$1,916.17
59	$1,609.64	$1,971.81	$1,533.95	$1,879.09	$1,597.98	$1,957.53
60	$1,678.28	$2,055.89	$1,599.36	$1,959.22	$1,666.12	$2,041.00
61	$1,737.65	$2,128.62	$1,655.93	$2,028.51	$1,725.06	$2,113.20
62	$1,776.61	$2,176.35	$1,693.06	$2,074.00	$1,763.73	$2,160.57
63	$1,825.46	$2,236.19	$1,739.61	$2,131.02	$1,812.23	$2,219.98
64+	$1,855.14	$2,272.55	$1,767.90	$2,165.68	$1,841.70	$2,256.08

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross Blue Shield Association.

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 2023.

All references to "Highmark" in this communication are references to Highmark Inc., an independent licensee of the Blue Cross Blue Shield Association, and/or to one or more of its affiliated Blue companies.

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

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.

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

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

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

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 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.

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

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 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.

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

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 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 .