Health coverage on your terms.

Individual and family plans

For benefit period:
January 1 to December 31, 2026

HIGHMARK®

Because Life.™

Say hello to a great health plan.

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

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

Why choose a Highmark health plan?

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

1 Expert care, close to home.

Highmark invests big in a patient-first approach to care, with easy access to high-quality, lower-cost health care services in your area. You can also seek care from Allegheny Health Network (AHN), a variety of independent providers, and, with some plans, UPMC.

2 Coverage that travels with you.

All of our plans come with access to **BlueCard®**. It connects you to the largest physician and hospital networks in the U.S. with over 2 million providers, including 97% of all hospitals.[1]

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

- Cleveland Clinic
- Mon Health Medical Center
- Kenmore Mercy Hospital
- St. Elizabeth Youngstown Hospital
- Adventhealth Orlando
- WVU Medicine
- Massachusetts General Hospital
- Roswell Park Cancer Institute
- United Hospital Center
- University of Texas MD Anderson Cancer Center

Keep in mind that BlueCard covers routine,[2] emergency, and urgent care for most plans.[3]

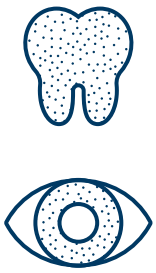
[1] According to the Blue Cross Blue Shield Association.

[2] Certain services may require you to work with your BlueCard-participating provider to obtain prior authorization.

[3] Some plans have limited BlueCard access. Please see page 24 for more information about how BlueCard works with each plan.

3 No red tape.

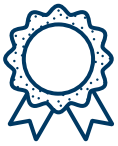
See whichever in-network doctors you want to see — no referral needed. Call **1-888-BLUE-428**, and we'll find a specialist for you. No hoops, no hoopla.



4 All your care, all in one plan.

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

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



5 Easy access to top-performing specialists.

BlueDistinction®

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

6 Mental health care that's exactly the right fit.

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

THE HIGHMARK MEMBER APP AND WEBSITE

Your entire plan at your fingertips.

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

And that's just for starters.

Turn the page for even more reasons to choose Highmark.

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

VIRTUAL HEALTH

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

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

24/7 NURSE LINE

Answers from a health pro, 24/7.

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

Your appointments, booked for you.

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

HEALTH SAVINGS ACCOUNT PLANS

Helping you save for today and tomorrow.

Health savings accounts (HSAs) let you put money away for things like medical costs, prescriptions, and more. They're available for Catastrophic and Bronze plans, and high-deductible health plans* with "HSA" in the plan name. Some of these plans also include a preventive eye exam for covered adults.**

* A high-deductible health plan (HDHP) is 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. Qualified HDHPs are often combined with a health savings account.

** See the Important Benefit Details section on page 62 for additional information on the adult preventive eye exam benefit.

VIRTUAL PHYSICAL CARE, POWERED BY SWORD

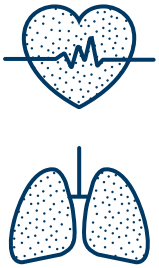
Physical care from the comfort of home.

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

DIABETES MANAGEMENT

Support to control diabetes.

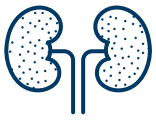
We offer programs to help with diabetes management. Eligible members with type 1 or type 2 diabetes have access to management tools, coaching, and clinical support to help you take better control of your health.



CHF AND COPD MANAGEMENT

Health coaching for CHF and COPD made personal.

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



KIDNEY CARE MANAGEMENT

Coordinating kidney care between doctor visits.

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

Need help with your health goals?

We’ve got you covered.

FITNESS

Hitting the gym has never been easier.

All our plans include a fitness extra with discounted rates and access to 10,000+ gyms nationwide.* You'll also get discounts for acupuncture and chiropractic care, nutritional counseling, personal training, and more. Visit **Highmark.com/FitnessWPA** to find a gym near you.

* Does not apply to digital-only fitness plans.

WELLNESS

Personalized support for health goals.

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

BLUE365®

Discounts to help you stay healthy and active.

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

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

Enrollment dates

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

1 Open Enrollment Period

November 1, 2025 – January 15, 2026

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

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

2 Special Enrollment Period

Can happen anytime throughout the year

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

If you think you're eligible for a Special Enrollment Period, you may be asked to submit documents to verify it. You can go to **HighmarkCatalog2026.com/WPA** for more information.

Metal levels

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

Bronze

60% of costs covered by your plan

40% out-of-pocket costs

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

Silver

70% of costs covered by your plan

30% out-of-pocket costs

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

Gold

80% of costs covered by your plan

20% out-of-pocket costs

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

Platinum

90% of costs covered by your plan

10% out-of-pocket costs

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

Extra Savings Silver

73 – 94% of costs covered by your plan

6 – 27% out-of-pocket costs

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

Please refer to page 18 for additional information on CSRs.

Financial help in the form of advance premium tax credits (APTCs) or cost-sharing reductions (CSRs) is available only on plans purchased through Pennie.

* 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.

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

Ways to save

Good news: There are two ways available to save for ACA members.
Even better news: Nearly 90% of our ACA members qualify to save.

Advance premium tax credits (APTC)

APTCs* may be applied — in advance — to lower what you pay each month for your premium on any plans through Pennie except catastrophic.

Cost-sharing reductions (CSR)

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

You can qualify for both an APTC and a CSR.

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

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

Financial help

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

Even if you don't qualify for cost-sharing reductions, you may be eligible for APTCs. Please refer to the Base plan options for your county. The chart below is a guide. Final eligibility will be determined through Pennie.

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

Who needs coverage?	Eligible for Medicaid	Eligible for CSRs and APTCs			Eligible for APTCs
	Medicaid Eligible Range (100 – 138% FPL)	Extra Savings Silver Plans 138 – 149% CSR plans	150 – 199% CSR plans	200 – 249% CSR plans	Standard 250 – 400%
Single	Less than $21,597	$21,598 – $23,474	$23,475 – $31,299	$31,300 – $39,124	$39,125 – $62,600
Family of 2	Less than $29,187	$29,188 – $31,724	$31,725 – $42,299	$42,300 – $52,874	$52,875 – $84,600
Family of 3	Less than $36,777	$36,778 – $39,974	$39,975 – $53,299	$53,300 – $66,624	$66,625 – $106,600
Family of 4	Less than $44,367	$44,368 – $48,224	$48,225 – $64,299	$64,300 – $80,374	$80,375 – $128,600
Family of 5	Less than $51,957	$51,958 – $56,474	$56,475 – $75,299	$75,300 – $94,124	$94,125 – $150,600
Family of 6	Less than $59,547	$59,548 – $64,724	$64,725 – $86,299	$86,300 – $107,874	$107,875 – $172,600
Family of 7	Less than $67,137	$67,138 – $72,974	$72,975 – $97,299	$97,300 – $121,624	$121,625 – $194,600
Family of 8	Less than $74,727	$74,728 – $81,224	$81,225 – $108,299	$108,300 – $135,374	$135,375 – $216,600

Most individuals and families with household incomes 100% or more of the federal poverty limit (FPL) will qualify for premium tax credits. These credits help lower the cost of health insurance coverage and are based on the second-lowest-cost Silver plan available in your area on **pennie.com**. The second-lowest-cost Silver plan is also known as the "benchmark plan." Premium tax credits vary by income.

Income below 138% FPL: If your income is below 138% FPL and your state has expanded Medicaid coverage, you qualify for Medicaid based only on your income.*

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

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

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

Check to see if you qualify for one or both types of help.
Call 855-387-8296.

Here's your Enrollment Checklist.

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

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

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

2026 Highmark products and plans

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

A quick way to narrow down your options.

Prefer to search online? Answer three simple questions on our website to get plan recommendations.
Visit Highmark.com/ComparePlansWPA.

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. **Laboratory services**
8. **Rehabilitative and habilitative services and devices**
9. **Preventive and wellness services and chronic disease management**
10. **Pediatric services, including dental and vision care**

Our networks and products

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

Together Blue EPO

The most affordable Highmark plan in western Pennsylvania.

Together Blue EPO gives you access to Allegheny Health Network (AHN) and select independent providers that deliver high-quality care at a lower cost. Plus, all Together Blue plans give you coast-to-coast coverage for emergency and urgent care with BlueCard.[1, 2]

Together Blue Virtual Choice

Together Blue EPO also offers a plan called Together Blue Virtual Choice, which makes getting affordable care simple and convenient.

Providers are available almost instantly, so it's easy to find times that work with your schedule. **And virtual visits for PCPs, specialists, behavioral health, and urgent care are covered at 100%.**

Plus, you can enroll in our virtual physical care program to relieve joint, back, and muscle pain from the comfort of home.

And eligible members with diabetes have access to health coaching, licensed endocrinology specialists, and a variety of digital care options to help better manage diabetes.[3]

my Direct Blue EPO

my Direct Blue EPO gives you in-network access to many community hospitals and doctors who deliver high-quality, lower-cost care.* And with the BlueCard program,[1, 2] you get in-network access to providers outside of Pennsylvania for routine, emergency, and urgent care, too.

[1] Certain services may require you to work with your BlueCard-participating provider to obtain prior authorization.

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

[3] Available services vary between whether the member has been diagnosed with type 1 or type 2 diabetes.

my Blue Access PPO

my Blue Access PPO gives you in-network access to Highmark's largest network of doctors and hospitals. And with the BlueCard program,[1, 2] you get in-network access to providers outside of Pennsylvania for routine, emergency, and urgent care, too.

With a PPO, you also get the flexibility to see out-of-network providers. Keep in mind, you'll pay more if you choose an out-of-network provider for routine care.

- Routine care from out-of-network providers is covered at two different levels:
  - Routine care from an out-of-network provider in Pennsylvania may cost more than seeing an in-network provider.
  - Routine care from an out-of-network provider outside of Pennsylvania may cost more than seeing an out-of-network provider in Pennsylvania.

Emergency and urgent care will always be covered at the same in-network rate, even if you see an out-of-network provider.

BlueCard Program coverage	Inside PA			Outside PA			
	In-Network	Out-of-Network		In-Network (BlueCard PPO Network)		Out-of Network (BlueCard PPO Network)	
	ER/Urgent Care/ Routine	ER/Urgent Care	Routine	ER/Urgent Care	Routine	ER/Urgent Care	Routine
Together Blue EPO	Yes	Yes	No	Yes	No	Yes	No
my Direct Blue EPO	Yes	Yes	No	Yes	Yes	Yes	No
my Blue Access PPO	Yes	Yes	Yes*	Yes	Yes	Yes	Yes**

* Out-of-Network In-State cost-sharing applies.

** Out-of-Network Out-of-State cost-sharing applies.

[1] Certain services may require you to work with your BlueCard-participating provider to obtain prior authorization.

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

Plans are available for residents of the counties highlighted below.

Together Blue EPO, my Direct Blue EPO, and my Blue Access PPO

my Direct Blue EPO and my Blue Access PPO

my Blue Access PPO

To see if your provider is in network, visit **HighmarkCatalog2026.com/WPAPro**.

Diabetes management

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

Diabetes tools and supplies*

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

Specific medications and supplies may change throughout the coverage year. Always check your formulary at **highmarkacaformulary.com** to check under what tier your drugs and supplies are listed.

* Out-of-pocket costs for these drugs and supplies will vary based upon the prescription coverage of the selected plan.
** Preferred medications may change. Please check the formulary website (**highmarkacaformulary.com**) for the most up-to-date information.

Key terms

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. For example, it could be $20 for a doctor visit or $30 for a specialist visit. If you owe a copay, you must pay it when you check in for your visit.

DEDUCTIBLE

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

EMERGENCY SERVICES

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

FORMULARY

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

OUT-OF-POCKET MAXIMUM

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

PRIMARY CARE PROVIDER (PCP)

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

URGENT CARE CENTER

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

VIRTUAL VISIT

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

Looking for plan details?

You're in the right place.

Here are a few questions to consider when looking for a plan that best fits your needs and budget.

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

To make it easier, we've sorted our plans by what's available where you live.

Just find your county and jump to that section.

* If you're a Centre county resident, you must live in one of the following ZIP codes to enroll in one of these plans: 16677, 16829, 16845, 16859, 16866, 16874.

You'll see plan summaries here. If you want any plan's full benefit list, visit **Highmarksbcs.com** or get a paper copy by calling **1-855-387-8296** (TTY/TDD: 711).

Allegheny, Butler, Erie, Washington, and Westmoreland counties

	Coverage Level		
	Major Events 10600 3 free PCP visits[1]	**Bronze 9200**[1]	**Bronze 3800**[1]
Plan Availability	Together Blue Major Events EPO Catastrophic 10600 - 3 free PCP visits[1] my Direct Blue Major Events EPO Catastrophic 10600 - 3 free PCP visits[1] my Blue Access Major Events PPO Catastrophic 10600 - 3 free PCP visits[1]	Together Blue EPO Bronze 9200[1] my Direct Blue EPO Bronze 9200[1] my Blue Access PPO Bronze 9200[1]	Together Blue EPO Bronze 3800[1] my Direct Blue EPO Bronze 3800[1] my Blue Access PPO Bronze 3800[1]
In-Network Deductible	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $3,800 Family: $7,600
In-Network, Out-of-Pocket Maximum	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $9,900 Family: $19,800
Primary Care Visit	First 3 visits free, then $0 after deductible	$0 after deductible	$65 copay
Specialist Visit	$0 after deductible	$0 after deductible	$65 copay
Outpatient Mental Health and Substance Abuse Visits	$0 after deductible	$0 after deductible	$65 copay
Physical and Occupational Therapy[2]	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test – Lab Services	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test – X-rays	$0 after deductible	$0 after deductible	$180 copay
Urgent Care[3]	$0 after deductible	$0 after deductible	$100 copay
Emergency Services	$0 after deductible	$0 after deductible	50% after deductible
Hospital Inpatient (including facility and professional)	$0 after deductible	$0 after deductible	50% after deductible
Pharmacy Summary[4]	$0 after deductible	$0 after deductible	Tier 1 drugs: $15 (not subject to deductible) All other tiers: 50% after deductible
Integrated Adult Dental and Vision Option[5]	No	No	Yes

[1] This plan is eligible for a health savings account (HSA).

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

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

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

[5] See pages 48 – 52 for adult dental and vision benefit details.

	Coverage Level			
	Silver 6000	**Silver 0[1]**	**Premier Silver 0**	**Gold 1700 HSA[2]**
Plan Availability	Together Blue EPO Silver 6000 my Direct Blue EPO Silver 6000 my Blue Access PPO Silver 6000	Together Blue EPO Silver 0[1] my Direct Blue EPO Silver 0[1] my Blue Access PPO Silver 0[1]	Together Blue EPO Premier Silver 0 my Direct Blue EPO Premier Silver 0 my Blue Access PPO Premier Silver 0	Together Blue EPO Gold 1700 HSA[2] my Direct Blue EPO Gold 1700 HSA[2] my Blue Access PPO Gold 1700 HSA[2]
In-Network Deductible	Individual: $6,000 Family: $12,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $1,700 Family: $3,400
In-Network, Out-of-Pocket Maximum	Individual: $8,600 Family: $17,200	Individual: $9,400 Family: $18,800	Individual: $9,700 Family: $19,400	Individual: $7,500 Family: $15,000
Primary Care Visit	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Specialist Visit	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Outpatient Mental Health and Substance Abuse Visits	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Physical and Occupational Therapy[3]	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Diagnostic Test – Lab Services	$55 copay	$60 copay	$60 copay	$15 copay after deductible
Diagnostic Test – X-rays	$125 copay	$175 copay	$175 copay	$15 copay after deductible
Urgent Care[4]	$100 copay	$100 copay	$90 copay	$30 copay after deductible
Emergency Services	$750 copay after deductible	$1,250 copay	$1,250 copay	$250 copay after deductible
Hospital Inpatient (including facility and professional)	$1,125 copay after deductible	$2,500 copay	$2,500 copay	$450 copay after deductible
Pharmacy Summary[5]	$10 not subject to deductible/$30 not subject to deductible/ $250 after deductible/ 50% after deductible	$5/$30/$250/50%	$5/$30/$250/50%	$0 after deductible/ $30 after deductible/ $150 after deductible/ 50% after deductible
Integrated Adult Dental and Vision Option[6]	No	Yes	Yes	No

	Coverage Level				
	Gold 1500	**Gold 0**	**Premier Gold 0**	**Premier Platinum 0**	**Premier Platinum 0[1]**
Plan Availability	Together Blue Virtual Choice EPO Gold 1500 my Direct Blue EPO Gold 1500 my Blue Access PPO Gold 1500	Together Blue EPO Gold 0 my Direct Blue EPO Gold 0 my Blue Access PPO Gold 0	Together Blue EPO Premier Gold 0 my Direct Blue EPO Premier Gold 0 my Blue Access PPO Premier Gold 0	Together Blue EPO Premier Platinum 0	my Direct Blue EPO Premier Platinum 0[1] my Blue Access PPO Premier Platinum 0[1]
In-Network Deductible	Individual: $1,500 Family: $3,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network, Out-of-Pocket Maximum	Individual: $8,300 Family: $16,600	Individual: $7,500 Family: $15,000	Individual: $6,900 Family: $13,800	Individual: $5,000 Family: $10,000	Individual: $5,000 Family: $10,000
Primary Care Visit	$35 copay	$20 copay	$15 copay	$0 copay	$0 copay
Specialist Visit	$35 copay	$20 copay	$15 copay	$0 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$35 copay	$20 copay	$15 copay	$0 copay	$0 copay
Physical and Occupational Therapy[3]	$35 copay	$20 copay	$40 copay	$0 copay	$0 copay
Diagnostic Test – Lab Services	$40 copay	$35 copay	$35 copay	$0 copay	$0 copay
Diagnostic Test – X-rays	$40 copay	$35 copay	$90 copay	$0 copay	$0 copay
Urgent Care[4]	$70 copay	$40 copay	$30 copay	$5 copay	$5 copay
Emergency Services	$450 copay	$400 copay	$350 copay	$100 copay	$100 copay
Hospital Inpatient (including facility and professional)	$725 copay after deductible	$725 copay	$525 copay	$325 copay	$325 copay
Pharmacy Summary[5]	$0/$30/$150/50%	$0/$30/$150/50%	$0/$25/$75/50%	$0/$10/$50/50%	$0/$10/$50/50%
Integrated Adult Dental and Vision Option[6]	Yes	Yes	Yes	Yes	Yes

[1] These plans are available directly from Highmark and are not available on **Pennie**. They do not qualify for advance premium tax credits or cost-sharing reductions.

[2] This plan is eligible for a health savings account (HSA), and has a non-embedded deductible and embedded maximum out-of-pocket.

[3] Limit of 30 combined physical and occupational therapy visits per benefit period. Limit does not apply to therapy services for the treatment of mental health or substance abuse.

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

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

[6] See pages 48 – 52 for adult dental and vision benefit details.

	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	Together Blue EPO Extra Savings Silver 0 my Direct Blue EPO Extra Savings Silver 0 my Blue Access PPO Extra Savings Silver 0	Together Blue EPO Premier Extra Savings Silver 0 my Direct Blue EPO Premier Extra Savings Silver 0 my Blue Access PPO Premier Extra Savings Silver 0	Together Blue EPO Extra Savings Silver 0 my Direct Blue EPO 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: $1,300 Family: $2,600	Individual: $1,250 Family: $2,500	Individual: $3,200 Family: $6,400
Primary Care Visit	$1 copay	$0 copay	$15 copay
Specialist Visit	$1 copay	$0 copay	$15 copay
Outpatient Mental Health and Substance Abuse Visits	$1 copay	$0 copay	$15 copay
Physical and Occupational Therapy[1]	$1 copay	$0 copay	$15 copay
Diagnostic Test - Lab Services	$1 copay	$0 copay	$30 copay
Diagnostic Test - X-rays	$1 copay	$0 copay	$50 copay
Urgent Care[2]	$5 copay	$5 copay	$30 copay
Emergency Services	$125 copay	$125 copay	$375 copay
Hospital Inpatient (including facility and professional)	$175 copay	$175 copay	$450 copay
Pharmacy Summary[3]	$0/$1/$5/50%	$0/$1/$5/50%	$0/$10/$50/50%
Integrated Adult 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	
	Premier Silver 0	Silver 3000	Premier Silver 0
Plan Availability	Together Blue EPO Premier Extra Savings Silver 0 my Direct Blue EPO Premier Extra Savings Silver 0 my Blue Access PPO Premier Extra Savings Silver 0	Together Blue EPO Extra Savings Silver 3000 my Direct Blue EPO Extra Savings Silver 3000 my Blue Access PPO Extra Savings Silver 3000	Together Blue EPO Premier Extra Savings Silver 0 my Direct Blue EPO Premier Extra Savings Silver 0 my Blue Access PPO Premier Extra Savings Silver 0
In-Network Deductible	Individual: $0 Family: $0	Individual: $3,000 Family: $6,000	Individual: $0 Family: $0
In-Network, Out-of-Pocket Maximum	Individual: $3,300 Family: $6,600	Individual: $7,000 Family: $14,000	Individual: $7,700 Family: $15,400
Primary Care Visit	$0 copay	$55 copay	$45 copay
Specialist Visit	$0 copay	$55 copay	$45 copay
Outpatient Mental Health and Substance Abuse Visits	$0 copay	$55 copay	$45 copay
Physical and Occupational Therapy[1]	$15 copay	$55 copay	$45 copay
Diagnostic Test - Lab Services	$60 copay	$55 copay	$60 copay
Diagnostic Test - X-rays	$90 copay	$125 copay	$175 copay
Urgent Care[2]	$10 copay	$100 copay	$90 copay
Emergency Services	$500 copay	$750 copay after deductible	$1,250 copay
Hospital Inpatient (including facility and professional)	$550 copay	$1,125 copay after deductible	$2,500 copay
Pharmacy Summary[3]	$0/$10/$50/50%	$10 not subject to deductible/ $30 not subject to deductible/ $250 after deductible/ 50% after deductible	$5/$30/$250/50%
Integrated Adult 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 therapy services for the treatment of mental health or substance abuse.

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

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

[4] See pages 48 – 52 for adult dental and vision benefit details.

Armstrong, Beaver, Cambria, Clarion, Crawford, Forest, and Warren counties

	Coverage Level		
	Major Events 10600 3 free PCP visits[1]	**Bronze 9200**[1]	**Bronze 3800**[1]
Plan Availability	my Direct Blue Major Events EPO Catastrophic 10600 - 3 free PCP visits[1] my Blue Access Major Events PPO Catastrophic 10600 - 3 free PCP visits[1]	my Direct Blue EPO Bronze 9200[1] my Blue Access PPO Bronze 9200[1]	my Direct Blue EPO Bronze 3800[1] my Blue Access PPO Bronze 3800[1]
In-Network Deductible	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $3,800 Family: $7,600
In-Network, Out-of-Pocket Maximum	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $9,900 Family: $19,800
Primary Care Visit	First 3 visits free, then $0 after deductible	$0 after deductible	$65 copay
Specialist Visit	$0 after deductible	$0 after deductible	$65 copay
Outpatient Mental Health and Substance Abuse Visits	$0 after deductible	$0 after deductible	$65 copay
Physical and Occupational Therapy[2]	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test – Lab Services	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test – X-rays	$0 after deductible	$0 after deductible	$180 copay
Urgent Care[3]	$0 after deductible	$0 after deductible	$100 copay
Emergency Services	$0 after deductible	$0 after deductible	50% after deductible
Hospital Inpatient (including facility and professional)	$0 after deductible	$0 after deductible	50% after deductible
Pharmacy Summary[4]	$0 after deductible	$0 after deductible	Tier 1 drugs: $15 (not subject to deductible) All other tiers: 50% after deductible
Integrated Adult Dental and Vision Option[5]	No	No	Yes

[1] This plan is eligible for a health savings account (HSA).

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

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

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

[5] See pages 48 – 52 for adult dental and vision benefit details.

	Coverage Level			
	Silver 6000	**Silver 0[1]**	**Premier Silver 0**	**Gold 1700 HSA[2]**
Plan Availability	my Direct Blue EPO Silver 6000 my Blue Access PPO Silver 6000	my Direct Blue EPO Silver 0[1] my Blue Access PPO Silver 0[1]	my Direct Blue EPO Premier Silver 0 my Blue Access PPO Premier Silver 0	my Direct Blue EPO Gold 1700 HSA[2] my Blue Access PPO Gold 1700 HSA[2]
In-Network Deductible	Individual: $6,000 Family: $12,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $1,700 Family: $3,400
In-Network, Out-of-Pocket Maximum	Individual: $8,600 Family: $17,200	Individual: $9,400 Family: $18,800	Individual: $9,700 Family: $19,400	Individual: $7,500 Family: $15,000
Primary Care Visit	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Specialist Visit	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Outpatient Mental Health and Substance Abuse Visits	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Physical and Occupational Therapy[3]	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Diagnostic Test - Lab Services	$55 copay	$60 copay	$60 copay	$15 copay after deductible
Diagnostic Test - X-rays	$125 copay	$175 copay	$175 copay	$15 copay after deductible
Urgent Care[4]	$100 copay	$100 copay	$90 copay	$30 copay after deductible
Emergency Services	$750 copay after deductible	$1,250 copay	$1,250 copay	$250 copay after deductible
Hospital Inpatient (including facility and professional)	$1,125 copay after deductible	$2,500 copay	$2,500 copay	$450 copay after deductible
Pharmacy Summary[5]	$10 not subject to deductible/$30 not subject to deductible/ $250 after deductible/ 50% after deductible	$5/$30/$250/50%	$5/$30/$250/50%	$0 after deductible/ $30 after deductible/ $150 after deductible/ 50% after deductible
Integrated Adult Dental and Vision Option[6]	No	Yes	Yes	No

	Coverage Level			
	Gold 1500	**Gold 0**	**Premier Gold 0**	**Premier Platinum 0[1]**
Plan Availability	my Direct Blue EPO Gold 1500 my Blue Access PPO Gold 1500	my Direct Blue EPO Gold 0 my Blue Access PPO Gold 0	my Direct Blue EPO Premier Gold 0 my Blue Access PPO Premier Gold 0	my Direct Blue EPO Premier Platinum 0[1] my Blue Access PPO Premier Platinum 0[1]
In-Network Deductible	Individual: $1,500 Family: $3,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network, Out-of-Pocket Maximum	Individual: $8,300 Family: $16,600	Individual: $7,500 Family: $15,000	Individual: $6,900 Family: $13,800	Individual: $5,000 Family: $10,000
Primary Care Visit	$35 copay	$20 copay	$15 copay	$0 copay
Specialist Visit	$35 copay	$20 copay	$15 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$35 copay	$20 copay	$15 copay	$0 copay
Physical and Occupational Therapy[3]	$35 copay	$20 copay	$40 copay	$0 copay
Diagnostic Test – Lab Services	$40 copay	$35 copay	$35 copay	$0 copay
Diagnostic Test – X-rays	$40 copay	$35 copay	$90 copay	$0 copay
Urgent Care[4]	$70 copay	$40 copay	$30 copay	$5 copay
Emergency Services	$450 copay	$400 copay	$350 copay	$100 copay
Hospital Inpatient (including facility and professional)	$725 copay after deductible	$725 copay	$525 copay	$325 copay
Pharmacy Summary[5]	$0/$30/$150/50%	$0/$30/$150/50%	$0/$25/$75/50%	$0/$10/$50/50%
Integrated Adult Dental and Vision Option[6]	Yes	Yes	Yes	Yes

[1] These plans are available directly from Highmark and are not available on **Pennie**. They do not qualify for advance premium tax credits or cost-sharing reductions.

[2] This plan is eligible for a health savings account (HSA), and has a non-embedded deductible and embedded maximum-out-of-pocket.

[3] Limit of 30 combined physical and occupational therapy visits per benefit period. Limit does not apply to therapy services for the treatment of mental health or substance abuse.

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

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

[6] See pages 48 – 52 for adult dental and vision benefit details.

	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 Direct Blue EPO Extra Savings Silver 0 my Blue Access PPO Extra Savings Silver 0	my Direct Blue EPO Premier Extra Savings Silver 0 my Blue Access PPO Premier Extra Savings Silver 0	my Direct Blue EPO 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: $1,300 Family: $2,600	Individual: $1,250 Family: $2,500	Individual: $3,200 Family: $6,400
Primary Care Visit	$1 copay	$0 copay	$15 copay
Specialist Visit	$1 copay	$0 copay	$15 copay
Outpatient Mental Health and Substance Abuse Visits	$1 copay	$0 copay	$15 copay
Physical and Occupational Therapy[1]	$1 copay	$0 copay	$15 copay
Diagnostic Test - Lab Services	$1 copay	$0 copay	$30 copay
Diagnostic Test - X-rays	$1 copay	$0 copay	$50 copay
Urgent Care[2]	$5 copay	$5 copay	$30 copay
Emergency Services	$125 copay	$125 copay	$375 copay
Hospital Inpatient (including facility and professional)	$175 copay	$175 copay	$450 copay
Pharmacy Summary[3]	$0/$1/$5/50%	$0/$1/$5/50%	$0/$10/$50/50%
Integrated Adult 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	
	Premier Silver 0	**Silver 3000**	**Premier Silver 0**
Plan Availability	my Direct Blue EPO Premier Extra Savings Silver 0 my Blue Access PPO Premier Extra Savings Silver 0	my Direct Blue EPO Extra Savings Silver 3000 my Blue Access PPO Extra Savings Silver 3000	my Direct Blue EPO Premier Extra Savings Silver 0 my Blue Access PPO Premier Extra Savings Silver 0
In-Network Deductible	Individual: $0 Family: $0	Individual: $3,000 Family: $6,000	Individual: $0 Family: $0
In-Network, Out-of-Pocket Maximum	Individual: $3,300 Family: $6,600	Individual: $7,000 Family: $14,000	Individual: $7,700 Family: $15,400
Primary Care Visit	$0 copay	$55 copay	$45 copay
Specialist Visit	$0 copay	$55 copay	$45 copay
Outpatient Mental Health and Substance Abuse Visits	$0 copay	$55 copay	$45 copay
Physical and Occupational Therapy[1]	$15 copay	$55 copay	$45 copay
Diagnostic Test – Lab Services	$60 copay	$55 copay	$60 copay
Diagnostic Test – X-rays	$90 copay	$125 copay	$175 copay
Urgent Care[2]	$10 copay	$100 copay	$90 copay
Emergency Services	$500 copay	$750 copay after deductible	$1,250 copay
Hospital Inpatient (including facility and professional)	$550 copay	$1,125 copay after deductible	$2,500 copay
Pharmacy Summary[3]	$0/$10/$50/50%	$10 not subject to deductible/ $30 not subject to deductible/ $250 after deductible/ 50% after deductible/	$5/$30/$250/50%
Integrated Adult 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 therapy services for the treatment of mental health or substance abuse.

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

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

[4] See pages 48 – 52 for adult dental and vision benefit details.

Bedford, Blair, Cameron, Centre*, Clearfield, Elk, Fayette, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, and Venango counties

* If you're a Centre county resident, you must live in one of the following ZIP codes to enroll in one of these plans: 16677, 16829, 16845, 16859, 16866, 16874.

	Coverage Level		
	Major Events 10600 3 free PCP visits[1]	**Bronze 9200**[1]	**Bronze 3800**[1]
Plan Availability	my Blue Access Major Events PPO Catastrophic 10600 - 3 free PCP visits[1]	my Blue Access PPO Bronze 9200[1]	my Blue Access PPO Bronze 3800[1]
In-Network Deductible	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $3,800 Family: $7,600
In-Network, Out-of-Pocket Maximum	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $9,900 Family: $19,800
Primary Care Visit	First 3 visits free, then $0 after deductible	$0 after deductible	$65 copay
Specialist Visit	$0 after deductible	$0 after deductible	$65 copay
Outpatient Mental Health and Substance Abuse Visits	$0 after deductible	$0 after deductible	$65 copay
Physical and Occupational Therapy[2]	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test – Lab Services	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test – X-rays	$0 after deductible	$0 after deductible	$180 copay
Urgent Care[3]	$0 after deductible	$0 after deductible	$100 copay
Emergency Services	$0 after deductible	$0 after deductible	50% after deductible
Hospital Inpatient (including facility and professional)	$0 after deductible	$0 after deductible	50% after deductible
Pharmacy Summary[4]	$0 after deductible	$0 after deductible	Tier 1 drugs: $15 (not subject to deductible) All other tiers: 50% after deductible
Integrated Adult Dental and Vision Option[5]	No	No	Yes

* If you're a Centre county resident, you must live in one of the following ZIP codes to enroll in one of these plans: 16677, 16686, 16829, 16845, 16859, 16866, 16874.

[1] This plan is eligible for a health savings account (HSA).

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

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

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

[5] See pages 48 – 52 for adult dental and vision benefit details.

	Coverage Level			
	Silver 6000	**Silver 0[1]**	**Premier Silver 0**	**Gold 1700 HSA[2]**
Plan Availability	my Blue Access PPO Silver 6000	my Blue Access PPO Silver 0[1]	my Blue Access PPO Premier Silver 0	my Blue Access PPO Gold 1700 HSA[2]
In-Network Deductible	Individual: $6,000 Family: $12,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $1,700 Family: $3,400
In-Network, Out-of-Pocket Maximum	Individual: $8,600 Family: $17,200	Individual: $9,400 Family: $18,800	Individual: $9,700 Family: $19,400	Individual: $7,500 Family: $15,000
Primary Care Visit	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Specialist Visit	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Outpatient Mental Health and Substance Abuse Visits	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Physical and Occupational Therapy[3]	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Diagnostic Test – Lab Services	$55 copay	$60 copay	$60 copay	$15 copay after deductible
Diagnostic Test – X-rays	$125 copay	$175 copay	$175 copay	$15 copay after deductible
Urgent Care[4]	$100 copay	$100 copay	$90 copay	$30 copay after deductible
Emergency Services	$750 copay after deductible	$1,250 copay	$1,250 copay	$250 copay after deductible
Hospital Inpatient (including facility and professional)	$1,125 copay after deductible	$2,500 copay	$2,500 copay	$450 copay after deductible
Pharmacy Summary[5]	$10 not subject to deductible/$30 not subject to deductible/ $250 after deductible/ 50% after deductible	$5/$30/$250/50%	$5/$30/$250/50%	$0 after deductible/ $30 after deductible/ $150 after deductible/ 50% after deductible
Integrated Adult Dental and Vision Option[6]	No	Yes	Yes	No

	Coverage Level			
	Gold 1500	**Gold 0**	**Premier Gold 0**	**Premier Platinum 0[1]**
Plan Availability	my Blue Access PPO Gold 1500	my Blue Access PPO Gold 0	my Blue Access PPO Premier Gold 0	my Blue Access PPO Premier Platinum 0[1]
In-Network Deductible	Individual: $1,500 Family: $3,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network, Out-of-Pocket Maximum	Individual: $8,300 Family: $16,600	Individual: $7,500 Family: $15,000	Individual: $6,900 Family: $13,800	Individual: $5,000 Family: $10,000
Primary Care Visit	$35 copay	$20 copay	$15 copay	$0 copay
Specialist Visit	$35 copay	$20 copay	$15 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$35 copay	$20 copay	$15 copay	$0 copay
Physical and Occupational Therapy[3]	$35 copay	$20 copay	$40 copay	$0 copay
Diagnostic Test – Lab Services	$40 copay	$35 copay	$35 copay	$0 copay
Diagnostic Test – X-rays	$40 copay	$35 copay	$90 copay	$0 copay
Urgent Care[4]	$70 copay	$40 copay	$30 copay	$5 copay
Emergency Services	$450 copay	$400 copay	$350 copay	$100 copay
Hospital Inpatient (including facility and professional)	$725 copay after deductible	$725 copay	$525 copay	$325 copay
Pharmacy Summary[5]	$0/$30/$150/50%	$0/$30/$150/50%	$0/$25/$75/50%	$0/$10/$50/50%
Integrated Adult Dental and Vision Option[6]	Yes	Yes	Yes	Yes

* If you're a Centre county resident, you must live in one of the following ZIP codes to enroll in one of these plans: 16677, 16686, 16829, 16845, 16859, 16866, 16874.

[1] These plans are available directly from Highmark and are not available on **Pennie**. They do not qualify for advance premium tax credits or cost-sharing reductions.

[2] This plan is eligible for a health savings account (HSA), and has a non-embedded deductible and embedded maximum out-of-pocket.

[3] Limit of 30 combined physical and occupational therapy visits per benefit period. Limit does not apply to therapy services for the treatment of mental health or substance abuse.

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

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

[6] See pages 48 – 52 for adult dental and vision benefit details.

	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 Savings Silver 0	my Blue Access PPO Premier 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: $1,300 Family: $2,600	Individual: $1,250 Family: $2,500	Individual: $3,200 Family: $6,400
Primary Care Visit	$1 copay	$0 copay	$15 copay
Specialist Visit	$1 copay	$0 copay	$15 copay
Outpatient Mental Health and Substance Abuse Visits	$1 copay	$0 copay	$15 copay
Physical and Occupational Therapy[1]	$1 copay	$0 copay	$15 copay
Diagnostic Test - Lab Services	$1 copay	$0 copay	$30 copay
Diagnostic Test - X-rays	$1 copay	$0 copay	$50 copay
Urgent Care[2]	$5 copay	$5 copay	$30 copay
Emergency Services	$125 copay	$125 copay	$375 copay
Hospital Inpatient (including facility and professional)	$175 copay	$175 copay	$450 copay
Pharmacy Summary[3]	$0/$1/$5/50%	$0/$1/$5/50%	$0/$10/$50/50%
Integrated Adult 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	
	Premier Silver 0	Silver 3000	Premier Silver 0
Plan Availability	my Blue Access PPO Premier Extra Savings Silver 0	my Blue Access PPO Extra Savings Silver 3000	my Blue Access PPO Premier Extra Savings Silver 0
In-Network Deductible	Individual: $0 Family: $0	Individual: $3,000 Family: $6,000	Individual: $0 Family: $0
In-Network, Out-of-Pocket Maximum	Individual: $3,300 Family: $6,000	Individual: $7,000 Family: $14,000	Individual: $7,700 Family: $15,400
Primary Care Visit	$0 copay	$55 copay	$45 copay
Specialist Visit	$0 copay	$55 copay	$45 copay
Outpatient Mental Health and Substance Abuse Visits	$0 copay	$55 copay	$45 copay
Physical and Occupational Therapy[1]	$15 copay	$55 copay	$45 copay
Diagnostic Test - Lab Services	$60 copay	$55 copay	$60 copay
Diagnostic Test - X-rays	$90 copay	$125 copay	$175 copay
Urgent Care[2]	$10 copay	$100 copay	$90 copay
Emergency Services	$500 copay	$750 copay after deductible	$1,250 copay
Hospital Inpatient (including facility and professional)	$550 copay	$1,125 copay after deductible	$2,500 copay
Pharmacy Summary[3]	$0/$10/$50/50%	$10 not subject to deductible/ $30 not subject to deductible/ $250 after deductible/ 50% after deductible/	$5/$30/$250/50%
Integrated Adult Dental and Vision Option[4]	Yes	No	Yes

* If you're a Centre county resident, you must live in one of the following ZIP codes to enroll in one of these plans: 16677, 16686, 16829, 16845, 16859, 16866, 16874.

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

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

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

[4] See pages 48 – 52 for adult dental and vision benefit details.

Vision and dental benefits

Plans that include adult vision and dental

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

You can find adult dental and vision benefits on pages 50 – 52 and pediatric dental and vision benefits on pages 54 – 58.

Vision coverage

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

Dental coverage

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

It pays to have dental coverage

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

* Three cleanings per year.

[1] https://www.dentaly.org/us/oral-hygiene/teeth-cleaning/#How_much_does_a_dental_cleaning_cost, last accessed May 8, 2025; https://www.dentaly.org/us/panoramic-dental-xray/, last accessed May 8, 2025

[2] https://www.dentaly.org/us/tooth-filling/#How_much_do_fillings_cost, last accessed May 8, 2025

[3] https://www.dentaly.org/us/tooth-extraction/#How_much_does_tooth_removal_cost_in_the_US, last accessed May 8, 2025

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

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

In-network

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

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

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

Eyeglass benefit - frame		Average retail value	
Non-collection frame allowance (retail):		Up to $130	Up to $150
Davis Vision Frame Collection[2] (in lieu of allowance):	Fashion level	Up to $125	Included
	Designer level	Up to $175	Included
	Premier level	Up to $225	Included

Contact lens benefit (in lieu of eyeglasses)		
Non-collection contact lenses: materials allowance		Up to $150
Collection contact lenses[2] (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] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

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

One-year eyeglass breakage warranty included.

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

To find a provider in the Davis Vision Network, visit **HighmarkCatalog2026.com/WPA**.

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

Dental Benefits			
Annual deductible per insured person		$50 per calendar year	
Annual deductible per insured family		$150 per calendar year	
Annual maximum per insured person		$1,500	
Covered services:	Policy pays		Elimination period
	In network	Out of network	
Oral evaluations (exams)	100%	0%	None
Radiographs (all X-rays)	100%	0%	None
Prophylaxis (cleanings — 3 per benefit period)	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 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 set amount that the Policy will pay for covered services provided by a participating dentist. Participating dentists accept the plan allowance as payment in full.

Adult dental benefits utilize the Concordia Advantage Network. Members must use a United Concordia provider. United Concordia is a separate company administering dental benefits. There is no out-of-network coverage for this benefit.

Our dental plan uses the Concordia Advantage network. To find in-network dentists, visit **HighmarkCatalog2026.com/WPA**.

Notes

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

In-network

Network benefit (Independents and Visionworks)[1]	Frequency - once every:	Members under 19 years of age[2]
Eye examination including dilation (when professionally indicated)*	12 months	$0 copay
Spectacle lenses[3]**	12 months	$0 copay
Frame**	12 months	$0 copay
Contact lenses (in lieu of eyeglass)**	12 months	$0 copay

Eyeglass benefit - spectacle lenses	Member charges
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[4] (standard/premium/ultra/ultimate)	$50/$90/$140/$175
High-index lenses (thinner and lighter)	$55/$120
Polarized lenses	$75
Scratch protection plan: single vision/multifocal lenses	$20/$40
Plastic photosensitive lenses	$65

Eyeglass benefit - frame[5]	Member charges
Davis Vision exclusive collection (in lieu of allowance)	
Fashion/Designer/Premier - member charge (if applicable)	$0/$0/$0
Non-collection frame allowance (retail)	Up to $150 Plus a 20% discount on any overage

Contact lens benefit (in lieu of eyeglasses)	
Contact lenses: 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[6] (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

[1] 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.

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

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

[4] 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.

[5] Collection frames will be covered at 100%. If a non-collection frame is selected, a $150 allowance will be applied. For any amount over $150 on a non-collection frame, the member will be responsible for 20% of the cost of the overage.

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

* Subject to deductible on Major Events/Catastrophic plans.

** Subject to deductible on high-deductible plans (that include an HSA) and Major Events/Catastrophic plans.

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

These plans will pay benefits for covered services shown below subject to exclusions and other Policy terms.
Payment is based on the plan allowance for the specific covered service.
There is no waiting period on covered services.

Dental benefits	All plans except high-deductible health plans that include an HSA and Major Events/ Catastrophic health plans	High-deductible health plans that include an HSA	Major Events/ Catastrophic health plans
Contract year deductible per member	$0	Expenditures for medical, dental, and vision care all contribute to the member's deductible.	Expenditures for medical, dental, and vision care all contribute to the member's deductible.
Annual maximum per member	Unlimited	Unlimited	Unlimited
Out-of-pocket year maximum per member	Expenditures for medical, dental, and vision care all contribute to the member's out-of-pocket maximum.	Expenditures for medical, dental, and vision care all contribute to the member's out-of-pocket maximum.	Expenditures for medical, dental, and vision care all contribute to the member's out-of-pocket maximum.
Network	**Advantage**	**Advantage**	**Advantage**
Covered services	Policy pays at participating dentists		
Oral evaluations (exams)	100%	100%	Coinsurance matches medical coinsurance (after deductible)
Radiographs (all X-rays)	100%	100%	
Prophylaxis (cleanings)	100%	100%	
Fluoride treatments	100%	100%	
Sealants	100%	100%	
Space maintainers	100%	100%	
Crowns, crown repair, inlays, and onlays	50%	Coinsurance matches medical coinsurance (after deductible)	
Basic restorative (anterior composite, anterior amalgam, and posterior amalgam)	50%	Coinsurance matches medical coinsurance (after deductible)	
Simple extractions	50%	Coinsurance matches medical coinsurance (after deductible)	
Surgical extractions	50%	Coinsurance matches medical coinsurance (after deductible)	
Oral surgery	50%	Coinsurance matches medical coinsurance (after deductible)	
Apicoectomy/ periradicular surgery	50%	Coinsurance matches medical coinsurance (after deductible)	

Dental benefits	All plans except high-deductible health plans that include an HSA and Major Events/ Catastrophic health plans	High-deductible health plans that include an HSA	Major Events/ Catastrophic health plans
Network	**Advantage**	**Advantage**	**Advantage**
Consultations	100%	Coinsurance matches medical coinsurance (after deductible)	
General anesthesia and/or IV sedation	50%	Coinsurance matches medical coinsurance (after deductible)	
Occlusal Guard	100%	Coinsurance matches medical coinsurance (after deductible)	
Palliative treatment (emergency)	100%	Coinsurance matches medical coinsurance (after deductible)	
Endodontics (root canals, etc.)	50%	Coinsurance matches medical coinsurance (after deductible)	
Surgical periodontics	50%	Coinsurance matches medical coinsurance (after deductible)	
Nonsurgical periodontics	50%	Coinsurance matches medical coinsurance (after deductible)	
Periodontal maintenance	50%	Coinsurance matches medical coinsurance (after deductible)	
Prosthodontics (fixed partial dentures)	50%	Coinsurance matches medical coinsurance (after deductible)	
Prosthetics (complete dentures, adjustments, and repairs)	50%	Coinsurance matches medical coinsurance (after deductible)	
Implant services	50%	Coinsurance matches medical coinsurance (after deductible)	
Maxillofacial prosthetics	Not covered		
Medically necessary orthodontics	50%	Coinsurance matches medical coinsurance (after deductible)	
Cosmetic orthodontic services	Not covered		

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

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

Participating dentists accept contracted plan allowance as payment in full for services. **There is no coverage for services provided by out-of-network providers.**

Our dental plan uses the Concordia Advantage network. To find in-network dentists, visit **HighmarkCatalog2026.com/WPA**.

Pediatric dental benefits (continued)

Medically necessary orthodontics coverage

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

1. In accordance with the generally accepted standards of medical/dental practice;

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and

3. Not primarily for the convenience of the patient or physician/dentist, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

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

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

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

Coverage of medically necessary orthodontics

1. Orthodontic treatment must be Medically Necessary and be the only method capable of:

   a) Preventing irreversible damage to the insured person's teeth or their supporting structures and,

   b) Restoring the insured person's oral structure to health and function.

2. The insured person must have a fully erupted set of permanent teeth to be eligible for comprehensive, Medically Necessary orthodontic services for handicapping malocclusions of the adult dentition.

3. Other orthodontic covered services include: pre-orthodontic treatment visit for completion of HLD (NJ-Mod2) form, diagnostic photographs and panoramic radiographs; limited treatment for the primary, transitional and adult dentition; interceptive treatment for the primary transitional dentition; minor treatment to control harmful habits; continuation of transfer cases or cases started prior to the insured person's Effective Date; orthognathic surgical cases with comprehensive orthodontic treatment; placement and removal of orthodontic appliances; repairs to orthodontic appliances; replacement of lost or broken retainer; rebonding or recementing of brackets and/or bands; and removal of appliances by a provider that did not start the case when requested by report.

4. All Medically Necessary orthodontic services require prior approval and a written plan of care.

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

Important Benefit Details

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

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

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

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

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

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

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

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

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

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

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

Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.

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.

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

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

Additional Disclosures

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

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

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

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

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

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

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

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

*Other providers are available in our network.

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield or Highmark Coverage Advantage Inc.

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

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

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with:

Civil Rights Coordinator
P.O. Box 22492
Pittsburgh, PA 15222
Phone: 1-866-286-8295 (TTY: 711), Fax: 412-544-2475
Email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD)

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

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

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

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

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

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

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

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

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

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

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

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

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