Part III Actuarial Memorandum

Highmark Inc.

Individual Rate Filing

Effective January 1, 2027

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I. General Information

Document Overview

This document contains the Part III Actuarial Memorandum for Highmark Inc.'s ("Highmark", "Company") individual block of business rate filing, for products with an effective date of January 1, 2027. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This information is intended for use by the Pennsylvania Insurance Department ("Department"), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Highmark's rate filing. However, we recognize that this certification may become a public document. Highmark makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this actuarial memorandum that would result in the creation of any duty or liability under any theory of law by Highmark.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

I.1 Company Identifying Information:

- Company Legal Name: Highmark Inc.
- State: The Commonwealth of Pennsylvania has regulatory authority over these policies.
- HIOS Issuer ID: 33709
- Market: Individual
- Effective Date: January 1, 2027

I.2 Company Contact Information:

- Primary Contact Name: [redacted]
- Primary Contact Telephone Number: [redacted]
- Primary Contact Email Address: [redacted]

II. Proposed Rate Changes

For all rate changes by plan, see the 'Cumulative Rate Change % (over 12 mos prior)' found in Worksheet 2, line 1.11 of the URRT. The rate change varies by plan due to an update in several of our pricing factors and changes in cost sharing required to meet Actuarial Value and other cost sharing restrictions under the Affordable Care Act.

The primary drivers of the rate increase are cost and utilization trend and morbidity impacts of the expiration of the enhanced advanced premium tax credits.

In accordance with the Department's April 7, 2026 rate filing guidance, this filing assumes the enhanced advance premium tax credits ("enhanced premium subsidies") will not be restored for Plan Year 2027. Additionally, this filing assumes the federal government continues to not fund the cost sharing reduction subsidies. Finally, in accordance with the Department's June 12, 2026 objection letter, the impact of the state 1332 Reinsurance program is captured using the prescribed parameters of $60,000 attachment point, 34% coinsurance rate, and $100,000 reinsurance cap.

Highmark is streamlining its individual ACA filing process in Pennsylvania. For Plan Year 2027, all plans previously offered under the Highmark Coverage Advantage ("HCA") entity will be withdrawn. Concurrently, all impacted members and their corresponding plans will be mapped into the Highmark Inc. entity in Pennsylvania, ensuring a seamless continuation of coverage and services for our members.

Modifications to the rate development may likely be necessary if significant unforeseen events occur. For example, this filing is being resubmitted due to the fact that the 2027 Notice of Benefit & Payment Parameters ("NBPP") was not finalized by CMS before our initial submission. There remain significant unknown outcomes that are under discussion at the federal level such as restoration of enhanced advance premium tax credits, and modifications of Cost Share Reductions methodology. Some additional examples include, but are not limited to, other changes in legislation/regulations (including rules, regulatory guidance, etc.), material provider contracting changes, or changes in the participation of QHP issuers that would materially impact risk adjustment transfer amounts. As a result, the Company reserves the right to submit a revised filing.

III. Experience and Current Period Premium, Claims, and Enrollment

III.1 Paid through Date:

Experience Period claims were based on incurred Calendar Year 2025, paid through February 2026. This includes 2025 experience in Affordable Care Act compliant plans. Highmark did not offer any transitional plans in 2025.

III.2 Current Date:

The current date shown represents a snapshot of February 1, 2026.

III.3 Allowed and Paid Claims Incurred During the Experience Period:

- Historical Experience: We chose Highmark's current experience for the individual block of business for the period January 1, 2025 through December 31, 2025, with claims paid through February 2026 as the basis for the 2027 projected individual market pricing.

- Claims Incurred During the 12-month Experience Period: Worksheet 1, Section I shows our best estimate of the amount of claims that were incurred during the 12-month experience period for Highmark's individual book-of-business. This section includes:

    - The amount of claims which were processed through Company's claims system,

    - Claims processed outside of the Company's claims system, and

    - Our best estimate of claims incurred but not paid as of the paid through date stated above.

- Method for Determining Allowed Claims: For non-capitated claims, the allowed charges are summarized from the Company's detailed claim-level historical data. This experience includes 2025 claims for Affordable Care Act compliant business. For capitated and other off-system claims, historical capitations and experience were tabulated and added to the claims.

- Paid Claims: We also summarized the paid claims from detailed member records. The paid-to-allowed ratio for the experience period reflects the 2025 plan designs chosen by each member.

- Incurred but Not Paid (IBNR) Claims Estimate: The Company is using a completion factor of 0.960 to include IBNR medical claims in allowed charges. The company is using a completion factor of 0.999 to include IBNR pharmacy claims in allowed charges. The IBNR completion factor was developed using our corporate reserving system for the Company's individual business. We applied it equally to both paid and allowed total claims (as a change to utilization) to complete the experience.

IV. Benefit Categories

The index rate of the experience period was summarized at the defined benefit categories included in Worksheet 1, Section II of the URRT.

The data provided in this section closely adheres to the preferred definitions of the Benefit Categories included in the URRT instructions, including the "Other Medical" category. The "Other Medical" category units reflect visits for PDN/home health, trips for ambulance and

procedures for DME/prosthetics. Prescription drugs utilization was converted to a "per 30-day" script count.

V. Projection Factors

Given the addition of the Together Blue product and associated membership to the projection period, the experience data is not given any credibility in the rate calculation. The factors entered on Worksheet 1 of the URRT for Morbidity Adjustment, Demographic Shift, Plan Design Changes, and Other are simply placeholders.

Please see the Manual Rate Adjustments section below for a discussion of the projection factors.

VI. Manual Rate Adjustments

VI.1 Source and Appropriateness of Experience Data Used

A manual rate was developed by blending 2025 experience from Highmark and HCA ACA claims for the February 1, 2026 snapshot membership, to approximate the anticipated 2027 Highmark population

VI.2 Adjustments Made to the Data

Since the expected 2027 population is used to develop the manual cost, no change in morbidity is required aside from an adjustment to account for out-of-network tiering on the PPO plans, and an adjustment to account for the anticipated morbidity impact resulting from the expiration of the enhanced premium subsidies described below. Similarly, the change in demographics adjustment is very small.

In accordance with the Department's guidance, the morbidity change related to the Reinsurance program is set to 1.000.

Out-of-network PPO Tiering Impact

This adjustment of 0.996 reflects the expected reduction in claims expense resulting from proposed out-of-network tiering on the PPO plan designs. The Company has experienced an extremely high level of out-of-area out-of-network claims in its current PPO plans. As a result, the existing PPO plan designs are being modified to create two out-of-network cost sharing tiers. Tier 1 (Out-of-Network In-State) for providers located within Pennsylvania, and Tier 2 (Out-of-Network Out-of-State) for providers located outside of Pennsylvania. Costs will vary depending on the tier of the provider chosen. The adjustment factor was derived by assuming that 90% of the CY2025 out-of-state out-of-network allowed spend would be eliminated due to this change.

Morbidity Impact from Expiration of Enhanced Premium Subsidies

This adjustment of 1.018 reflects the anticipated morbidity impact resulting from the expiration of the enhanced premium subsidies that were implemented by the American Rescue Plan Act

(ARPA) and extended by the Inflation Reduction Act (IRA) in 2026. Additional market changes include the expected "long tail" impact on enrollment and the risk pool, a shortened Open Enrollment Period for Plan Year 2027, stricter income verification requirements for consumers seeking financial assistance, and HR 1 Eligibility Changes for Lawfully Present Enrollees. The Company derived the adjustment factor from a member level lapse model that compared average allowed PMPM costs before and after assumed lapses caused by the loss of the enhanced premium subsidies. This adjustment factor lands comfortably within the Department's recommended range of 1.00 to 1.07.

The underlying manual data was further adjusted to account for changes in network, pharmacy rebates, and claim add-ons.

VI.3 Trend Factors

This development of the CY2027 rates reflects an annual trend rate of 10.3% (5.0% cost, 5.0% utilization) for medical and 8.7% (5.0% cost, 3.5% utilization) for pharmacy. These trends reflect Highmark's expectations regarding increases in in-network contractual reimbursement and out-of-network costs. These estimates measure and normalize for some of the more explainable variables such as high dollar claims, work days, provider contracting, demographics, and seasonality.

The medical trend represents a blended average for all medical types of services and is applied to the aggregate medical experience for pricing. Component data was not used in the development of the trend except pharmacy-specific projections were used to adjust the Pharmacy trend. The Pharmacy trend takes into account factors such as projected specialty drug use, pipeline drugs coming to market, and provider contracting. These trends represent assumed community-wide expectations. Claim variations due to the specific projected enrolled population in this single risk pool are reflected in the morbidity adjustment.

VII. Credibility of Experience

Given the addition of the Together Blue product and associated membership to the projection period, the experience data is not given any credibility in the rate calculation. Therefore, Highmark has chosen to develop the rate on a 100% manual basis.

VIII. Index Rate

The index rates as shown on Worksheet 1 of the URRT are simply the single risk pool average allowed claims for the Essential Health Benefits for the experience and projected populations, respectively, for Highmark. For the experience period, only non-grandfathered plans are included. The projection period Index Rate is not adjusted for reinsurance or risk adjustment programs or any other fee.

IX. Market Adjusted Index Rate [MAIR]

The Market Adjusted Index Rate is the Projected Index Rate further adjusted for reinsurance, risk adjustment, and the exchange user fee.

IX.1 Projected Reinsurance PMPM

In accordance with the Department's June 12, 2026 objection letter, the impact of the state 1332 Reinsurance Program is captured using the following parameters for 2027: an attachment point of $60,000, a coinsurance rate of 34%, and a cap of $100,000. Highmark estimated the impact of the reinsurance program under these tentative parameters by trending Highmark PA individual ACA CY2025 incurred claims by member to the CY2027 rating period, applying the parameters, and calculating the amount of incurred claims expected to be reimbursed by the program. The modeling produced an estimated incurred claims savings of 3.3%. This percentage was converted to a PMPM and adjusted to an equivalent allowed claim basis by dividing the PMPM by the paid-to-allowed factor and the composite effect of catastrophic eligibility and benefits in addition to EHB. This amount is reflected in worksheet 1 of the URRT.

IX.2 Projected Risk Adjustment PMPM

The estimated average risk score for Highmark's projected 2027 population was developed by using Highmark's 2025 claim diagnoses and the risk adjustment coefficients as finalized in the Notice of Benefit and Payment Parameters. Similarly, actuarial value factors and induced demand factors were estimated for Highmark based upon its projected 2027 population.

We estimated the statewide average risk transfer factors based on current market assumptions. We estimated the statewide average premium using current market premium assumptions with adjustments for anticipated rate changes for 2027.

The actual calculation of the risk transfer followed the risk transfer methodology as prescribed.

The analysis resulted in Highmark receiving from the risk adjustment pool. The $19.09 PMPM value shown in worksheet 1 of the URRT is developed by taking the expected risk transfer amount plus the projected High Cost Risk Pool charge and adjusting it to an equivalent allowed claims basis by dividing it by the paid-to-allowed factor and the composite effect of catastrophic eligibility and benefits in addition to EHB.

For the purposes of this rate filing, Highmark has assumed no adjustment to the projected risk adjustment transfer for the Risk Adjustment Data Validation (RADV) program.

IX.3 Exchange User Fee %

The 2.71% value shown in worksheet 1 of the URRT is developed by multiplying the 3% exchange user fee by the assumed percentage of on exchange membership. This calculated amount is then divided by the paid-to-allowed factor to bring it to an equivalent allowed claims basis and adjusted further for the composite effect of catastrophic eligibility and benefits in addition to EHB.

X. Plan Adjusted Index Rate [PAIR]

The Plan Adjusted Index Rates can be found on line 3.10, Worksheet 2 of the URRT. The PAIR rates are calculated by applying the allowable rating factors as described below to the Market Adjusted Index Rate.

X.1 AV and Cost Sharing Design of Plan

The AV and Cost Sharing allowable rating factor is comprised of the following components:

- The utilization due to differences in cost sharing is based on the factors calculated using a methodology prescribed in the Department's guidance relative to the weighted average. No differences due to health status are in these adjustments.

- The pricing AV for the benefits and cost sharing of the plan and a CSR load for the on-exchange silver plans.

Impact of Non-Payment of Cost Sharing Reduction Subsidies

In accordance with the Department's guidance, we have applied an additional adjustment to our AV pricing values for those Silver plans not offered exclusively off-exchange. This adjustment factor was 1.27 and represents the non-payment of Cost Sharing Reduction subsidies. Consistent with the Department's guidance, this adjustment falls within the prescribed range of 1.22 to 1.32.

Exhibit I shows the quantitative support for the CSR load. The tables on Exhibit I demonstrate three different methods for determining the load. The Company evaluated the three methods and elected to assume a 1.27 CSR load. Additionally, these values aligned with the results of the Department's ACA CSR Survey from February 2026. The Company intends to continue to monitor the CSR load development and adjust as necessary in future years.

In accordance with the May 2, 2025 CMS bulletin notice and the May 27, 2025 CMS FAQ, the Company estimated the CSRs paid for enrollees in PY2025 to be $34M. A modified version of the example method released in the CMS FAQ related to comparing EHB paid-to-allowed ratios was used since the actual CSRs paid cannot be quantified in the limited timeframe provided. The Company compared EHB paid-to-allowed ratios between each CSR plan variant to the standard plan and applied the differential to the actual EHB allowed claims in that variant. The Company relied on credible experience paid-to-allowed ratios for the CSR 87 and CSR 94 plan variants, and a blend of historical Pricing AVs with HHS-calculated AV for the standard plan because its experience was not credible.

In PY2027, the Company expects to collect $23M in additional revenue due to the CSR load factor. We also expect to pay out $23M on behalf of eligible enrollees. The projection of CSR payments was based on the same methodology that was used to estimate 2025 payments. The projection was adjusted for the expected mix shift in population between the silver variants from 2025 to 2027. These percentages were then applied to 2027 projected claims to determine the projected CSR payments. While the expected 2027 revenue attributable to CSR is slightly

higher than the expected payments, our 2025 experience suggests that payments exceeded revenue. Given the assumption sensitivities inherent in such a projection, we feel that the difference between projected revenue and claims is reasonable.

Impact of Restoration of Enhanced Premium Subsidies

As requested by the Department, if the enhanced premium subsidies are restored for Plan Year 2027, the morbidity load attributable to the expiring premium subsidies and projected enrollment would be impacted. Without knowing the timing and level of subsidies being restored, it is difficult to develop a point estimate but please accept a quantitative range. We would use a similar methodology to support the impact as last year and expect the premium rate impact to be less than 4%.

X.2 Provider Network Adjustment

The provider network adjustments are developed by dividing the plan level network factors by the overall weighted average from all plans.

X.3 Benefits in Addition to EHB

Non-EHB benefits are offered in several plans. Forty-two plans have an adult dental and vision benefit, six plans have an adult vision exam benefit, and forty-two plans have a hearing benefit.

X.4 Administrative Expense

The proposed rates reflect internal administrative costs including quality improvement administrative expenses. This cost was developed based on standard expense allocation methods.

X.5 Taxes and Fees:

The following fees were added:

- $0.18 PMPM for Risk Adjustment User Fee
- $0.39 PMPM for Patient Centered Outcomes Research Institute (PCORI) Fee
- 0.0% for the Health Insurance Provider Fee
- 0.0% for the PA Premium Tax

X.6 Profit (or Contribution to Surplus) & Risk Margin:

The profit/contingency factor is set to 1% as requested by the Department.

X.7 Catastrophic Adjustment

For catastrophic plans, we use a 0.92 factor for the specific eligibility adjustment.

XI. Calibration

XI.1 Age Curve Calibration:

The projected weighted average age factor for billable members is 1.7498. This factor is calculated by dividing the all members age factor of 1.7476 by the ratio of billable members to total members 0.9988. The age curve calibration factor is 1/1.7498 = 0.5715.

XI.2 Geographic Calibration Factor:

The projected weighted average geographic factor is 0.9808. Each Plan Adjusted Index Rate represents the rate for an average member with a geographic factor of 0.9808. The geographic calibration factor is 1/0.9808 = 1.0196.

XI.3 Tobacco Calibration Factor:

The projected weighted average tobacco factor is 1.0054. Each Plan Adjusted Index Rate represents the rate for an average member with a tobacco factor of 1.0054. The tobacco calibration factor is 1/1.0054 = 0.9946.

XI.4 Consumer Adjusted Premium Rate Development:

The calibrated plan adjusted index rate represents the base rate for an age factor of 1.0, geographic rating factor of 1.0 and tobacco rating factor of 1.0. Thus, the approximate premium for a specific member can be derived by multiplying this rate by the HHS age curve factor, the rating area factor on Worksheet 3 of the URRT, and the appropriate tobacco factor. Please note that this method will only produce approximate rates due to URRT rounding constraints.

XII. Projected Loss Ratio

The projected loss ratio for 2027 using the federally-prescribed MLR methodology is 91.3%.

XIII. AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based the Federal AV Calculator. Some plans did require an adjustment to the inputs entered into the AV calculator. Screen shots and certifications for these plans were submitted as part of Highmark's QHP application. When applicable and per CMS's guidance, a dummy AV Metal Value was applied to any terminated plans that fell out of the new de minimis range.

XIV. Membership Projections

Membership projections reflect Highmark's expectations for 2027. These projections reflect expected changes in market share due to market competition, relative price levels, changes in plan offerings (where applicable), and the impact of the expiration of the enhanced advanced premium tax credits.

Highmark expects membership in 2027 to follow a similar metal level distribution as the 2026 Individual ACA enrollment distribution.

For the Silver level plans, the projected membership by cost sharing subsidy levels is based on the observed distribution of ACA members that were eligible under the federal poverty levels as determined by the federal health insurance exchange. The projected enrollment by plan and subsidy level is as follows:

CSR Silver Plan Membership Distribution			
FPL	**Subsidy Level**	**% of Silver Membership**	**% of Total Membership**
<150%	94%	46.8%	5.6%
150%-200%	87%	24.0%	2.9%
200%-250%	73%	1.2%	0.1%
>250%	70%	28.0%	3.3%
Total		100.0%	11.9%

XV. Terminated Plans and Products

Plans in the 2025 experience period that will no longer be available in 2027 can be found in Exhibit II.

Highmark also has some plans that were offered only in 2026 (not offered in the experience period or in the projection period). These plans are shown in Exhibit II.

XVI. Plan Type

The Plan types listed in Worksheet 2, Section I of the Part I Unified Rate Review Template describe Highmark's plans adequately.

XVII. Actuarial Certification

I, [redacted], am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinions in the United States. All statements in this actuarial certification are accurate to the best of my knowledge and understanding. This filing is prepared in compliance with applicable Actuarial Standards of Practice. In completing this filing, I relied on data/information from other sources which was reviewed for reasonableness. This filing is prepared on behalf of Highmark to accompany its rate filing for the Individual Market on and off the Pennsylvania Exchange.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102),
- Developed in compliance with the applicable Actuarial Standards of Practice

- Reasonable in relation to the benefits provided and the population anticipated to be covered

- Neither excessive nor deficient.

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator. If any adjustments were required outside of the AV Calculator, appropriate certification has been provided to CMS through the QHP application process.

I certify that the geographic rating reflects only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

The Part I Unified Rate Review Template does not demonstrate the process used by Highmark to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Signed:



Title: Associate Actuary, Individual Markets

Date: July 31, 2026

XVIII. Exhibit I

Estimated CSR Shortfall Development



XIX. Exhibit II

Terminated Experience Period Plans

HIOS ID	Metal	Plan Name	2027 Mapping
33709PA0890002	Bronze	my Direct Blue EPO Bronze 7400 HSA - Custom Drug Benefit	N/A
33709PA0950001	Bronze	my Direct Blue EPO Bronze 7400 HSA - Custom Drug Benefit	N/A
33709PA0970002	Bronze	my Direct Blue Lehigh Valley EPO Bronze 3800	33709PA1480001
33709PA0970006	Gold	my Direct Blue Lehigh Valley EPO Gold 0	33709PA1480004
33709PA0970007	Silver	my Direct Blue Lehigh Valley EPO Silver 3500	33709PA1480003
33709PA0970008	Bronze	my Direct Blue Lehigh Valley EPO Bronze 8900	33709PA1480005
33709PA0970009	Silver	my Direct Blue Lehigh Valley EPO Silver 7000	33709PA1480006
33709PA0970010	Gold	my Direct Blue Lehigh Valley EPO Gold 1500	33709PA1480007
33709PA0980001	Bronze	my Direct Blue Lehigh Valley EPO Bronze 7400 HSA - Custom Drug Benefit	N/A
33709PA0980004	Gold	my Direct Blue Lehigh Valley EPO Gold 1700 HSA	33709PA1500003
33709PA0990001	Catastrophic	my Direct Blue Lehigh Valley Major Events EPO Catastrophic 9200 - 3 Free PCP Visits	33709PA1510001
33709PA1130001	Bronze	my Direct Blue Lehigh Valley EPO Bronze 3800 + Adult Dental and Vision	33709PA1490001
33709PA1130003	Silver	my Direct Blue Lehigh Valley EPO Silver 3500 + Adult Dental and Vision	33709PA1490003
33709PA1130005	Gold	my Direct Blue Lehigh Valley EPO Gold 0 + Adult Dental and Vision	33709PA1490004
33709PA1180001	Bronze	my Blue Access PPO Bronze 7400 HSA - Custom Drug Benefit	N/A
33709PA1340001	Gold	my Direct Blue EPO Premier Gold 0	33709PA0940006
33709PA1340002	Silver	my Direct Blue EPO Premier Silver 0	33709PA0940012
33709PA1350001	Gold	my Blue Access PPO Premier Gold 0	33709PA1160004
33709PA1350002	Silver	my Blue Access PPO Premier Silver 0	33709PA1160010
33709PA1360001	Gold	my Blue Access PPO Premier Gold 0 + Adult Dental and Vision	33709PA1170005
33709PA1360002	Silver	my Blue Access PPO Premier Silver 0 + Adult Dental and Vision	33709PA1170008
33709PA1370001	Bronze	my Blue Access PPO Bronze 7400 HSA - Custom Drug Benefit	N/A
33709PA1380001	Gold	my Blue Access PPO Premier Gold 0	33709PA1410004
33709PA1380002	Silver	my Blue Access PPO Premier Silver 0	33709PA1410009
33709PA1390001	Gold	my Blue Access PPO Premier Gold 0 + Adult Dental and Vision	33709PA1420004
33709PA1390002	Silver	my Blue Access PPO Premier Silver 0 + Adult Dental and Vision	33709PA1420007
33709PA1400001	Gold	my Direct Blue EPO Premier Gold 0 + Adult Dental and Vision	33709PA1450001
33709PA1400002	Silver	my Direct Blue EPO Premier Silver 0 + Adult Dental and Vision	33709PA1120007
33709PA1430001	Gold	my Direct Blue EPO Premier Gold 0	33709PA0870012
33709PA1430002	Silver	my Direct Blue EPO Premier Silver 0	33709PA0870018
33709PA1440001	Gold	my Direct Blue EPO Premier Gold 0 + Adult Dental and Vision	33709PA1150005
33709PA1440002	Silver	my Direct Blue EPO Premier Silver 0 + Adult Dental and Vision	33709PA1150008
33709PA1460001	Gold	my Direct Blue Lehigh Valley EPO Premier Gold 0	33709PA1480004
33709PA1460002	Silver	my Direct Blue Lehigh Valley EPO Premier Silver 0	33709PA1480009
33709PA1470001	Gold	my Direct Blue Lehigh Valley EPO Premier Gold 0 + Adult Dental and Vision	33709PA1490004
33709PA1470002	Silver	my Direct Blue Lehigh Valley EPO Premier Silver 0 + Adult Dental and Vision	33709PA1490007
33709PA1500001	Bronze	my Blue Access PPO Bronze 7400 HSA - Custom Drug Benefit	N/A
33709PA1520001	Gold	my Blue Access PPO Premier Gold 0	33709PA1480004
33709PA1520002	Silver	my Blue Access PPO Premier Silver 0	33709PA1480009
33709PA1530001	Gold	my Blue Access PPO Premier Gold 0 + Adult Dental and Vision	33709PA1490004
33709PA1530002	Silver	my Blue Access PPO Premier Silver 0 + Adult Dental and Vision	33709PA1490007

Terminated Plans Offered in 2026 Only

HIOS ID	Metal	Plan Name	2027 Mapping
33709PA1430003	Platinum	my Direct Blue EPO Premier Platinum 0	33709PA0870019
33709PA1440003	Platinum	my Direct Blue EPO Premier Platinum 0 + Adult Dental and Vision	33709PA1150009
33709PA1350003	Platinum	my Blue Access PPO Premier Platinum 0	33709PA1160011
33709PA1360003	Platinum	my Blue Access PPO Premier Platinum 0 + Adult Dental and Vision	33709PA1170009
33709PA1380003	Platinum	my Blue Access PPO Premier Platinum 0	33709PA1410010
33709PA1390003	Platinum	my Blue Access PPO Premier Platinum 0 + Adult Dental and Vision	33709PA1420008
33709PA1340003	Platinum	my Direct Blue EPO Premier Platinum 0	33709PA0940013
33709PA1400003	Platinum	my Direct Blue EPO Premier Platinum 0 + Adult Dental and Vision	33709PA1120008
33709PA1520003	Platinum	my Blue Access PPO Premier Platinum 0	33709PA1480010
33709PA1530003	Platinum	my Blue Access PPO Premier Platinum 0 + Adult Dental and Vision	33709PA1490008
33709PA1460003	Platinum	my Direct Blue Lehigh Valley EPO Premier Platinum 0	33709PA1480010
33709PA1470003	Platinum	my Direct Blue Lehigh Valley EPO Premier Platinum 0 + Adult Dental and Vision	33709PA1490008
33709PA1130006	Gold	my Direct Blue Lehigh Valley EPO Gold 1500 + Adult Dental and Vision	33709PA1490005