HIGHMARK.

All for Health.

2017 Health Insurance

Benefit Period January 1, 2017 to December 31, 2017

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

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

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

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

- Call **1-855-329-0690** (TTY/TDD 711)
- Visit your Highmark health insurance store
- Visit **DiscoverHighmark.com**
- Your insurance agent

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

Or you can contact the Marketplace at:

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

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

*Coverage may be provided or administered by Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Choice Company

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

Step 1

Know Your Dates

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

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

Special Enrollment Period

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

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

If you think a Special Enrollment Period may apply to you, you can learn more by visiting **HealthCare.gov.** You may be asked to submit documents that verify your eligibility.

Step 2

What's New, What Stays the Same

There are plan changes for 2017. Although the exact coverage you have today may not be available in 2017, Highmark may still have a plan to meet your needs. Or, it's possible that the plan with the best coverage for you may be found elsewhere on the Health Insurance Marketplace.

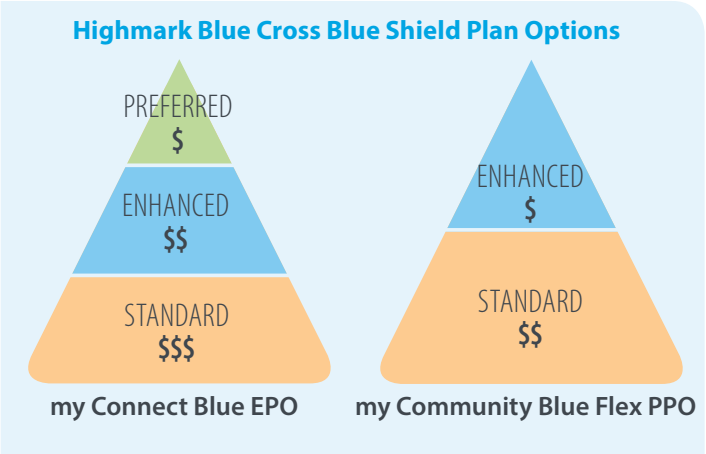
What's New

Highmark Blue Cross Blue Shield Plan Options

Highmark Blue Cross Blue Shield health plans have different provider network levels. These plans give you a choice among the doctors and hospitals that offer in-network services. Depending on the provider you choose, these plans may help you to save money on your out-of-pocket costs for care.

Highmark offers plans with two or three in-network value level of benefits depending on where you live. Providers participate at a specific level of benefits. At each level, you may pay a different amount. All levels offer the same high-quality care — no matter which level you use.

For example, you may pay less for your out-of-pocket costs and your health plan will pay more if you choose a provider who participates at the highest level of benefits. By choosing a provider at a lower level of benefits, you may pay more for your out-of-pocket costs and your health plan pays less.



my Connect Blue EPO

The **my Connect Blue EPO** plans have three value levels of benefits for in-network services: *Preferred, Enhanced and Standard*. When you choose doctors who participate at the *Preferred Value Level of Benefits*, you may pay the least in out-of-pocket costs. You may pay somewhat more when you select providers at the *Enhanced Value Level of Benefits*. For providers at the *Standard Value Level of Benefits*, you may pay the most. Allegheny Health Network providers participate at the Preferred value level of benefits.

my Community Blue Flex PPO

The **my Community Blue Flex PPO** plans have two value levels of benefits for in-network services: *Enhanced* and *Standard*. You can choose from many doctors or hospitals in the network. When you choose a doctor at the *Enhanced* level, you may spend less out of your own pocket in copays and coinsurance than if you use a doctor at the *Standard* level. You can choose your in-network doctors, labs, hospitals and other facilities based on convenience, past experience, recommendations and accreditations, as well as cost.

Outside of the counties where the my Connect Blue and my Community Blue Flex plans are offered, services received from providers participating in a local Blue plan, or BlueCard® program, are covered at the Enhanced value level of benefits.

Find a Doctor

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

New Prescription Drug Formulary for 2017

Essential Formulary

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

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

Most Highmark Blue Cross Blue Shield plans offer the Essential Formulary, which has:

- A closed formulary, meaning that the plan only pays for drugs on the formulary; non-formulary drugs are not covered
- Generics, brands and specialty drugs are mixed between the different tiers
- A four-tier structure where you can save money when your doctor prescribes drugs on the lower tiers

Please be aware, the new Essential Formulary may not include certain prescription drugs, that were covered under the 2016 Highmark plans. Please check **HighmarkEssentialFormulary.com** to see if your prescription drugs are covered for 2017. If you don't see your drug listed or your medication is listed as Non-formulary, please check with your doctor to see if a different drug option included on the Essential Formulary may be available.

Essential Formulary	
Tier 1	$ (least costly)
Tier 2	$$
Tier 3	$$$
Tier 4	$$$$ (most costly)

HCR Comprehensive Formulary for Comprehensive Care Flex Blue & Major Events Plans

These plans offer the HCR Comprehensive Formulary. This is an open formulary where your plan covers generics, brands and specialty formulary and non-formulary drugs. The Major Events catastrophic plan is available if you are under age 30 or have a financial hardship.

HCR Comprehensive Formulary	
Generic	$ (least costly)
Brand Formulary	$$
Non-Formulary	$$$
Specialty Drug	$$$$ (most costly)

Specialty Drugs

Specialty drugs are for complex, chronic conditions, such as multiple sclerosis or cancer and are available in Highmark formularies. These drugs have different cost sharing, because they are often more expensive and may require special handling, administration and monitoring. To ensure your safety, we only allow approved specialty pharmacies to deliver these drugs.

Active Choice Pharmacy Benefit

You may save money on drugs you take on a regular basis — for a chronic medical condition. By choosing our convenient home delivery option you may have your prescriptions (90-day supply) delivered to your home in safe, secure packaging. Or, you can use a retail pharmacy. But you must choose and may be notified about this program.

What Stays the Same

Metal Levels & Essential Health Benefits

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

Metal Levels

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

Essential Health Benefits

Highmark ACA plans include these essential health benefits:

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

2017 Highmark Blue Cross Blue Shield health plans are available on pages 8-24 for you to review. For more information on terms, please look at Your Health Care Glossary on page 26.

Step 3

How to Enroll

Do You Qualify for Financial Help?

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

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

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

You Will Need Important Enrollment & Financial Help Documents

Gather these documents to see if you're eligible for financial help. You will also need these to complete enrollment for yourself and every family member you want to enroll.

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

2017 Household Income Chart

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

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

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

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

Understanding Your Monthly Premium Rates

Review your base monthly premium rates for each plan on pages 29-34 of this brochure. The base premium rate listed is the maximum amount an individual* will pay every month. Find by:

- The county where you live (If you are under age 21, find either the county where you live or the county where you live with your parent/guardian.)
- The Highmark plan you wish to purchase
- Your age (and the age of each dependent)
- Your tobacco use (and the tobacco use of each dependent)

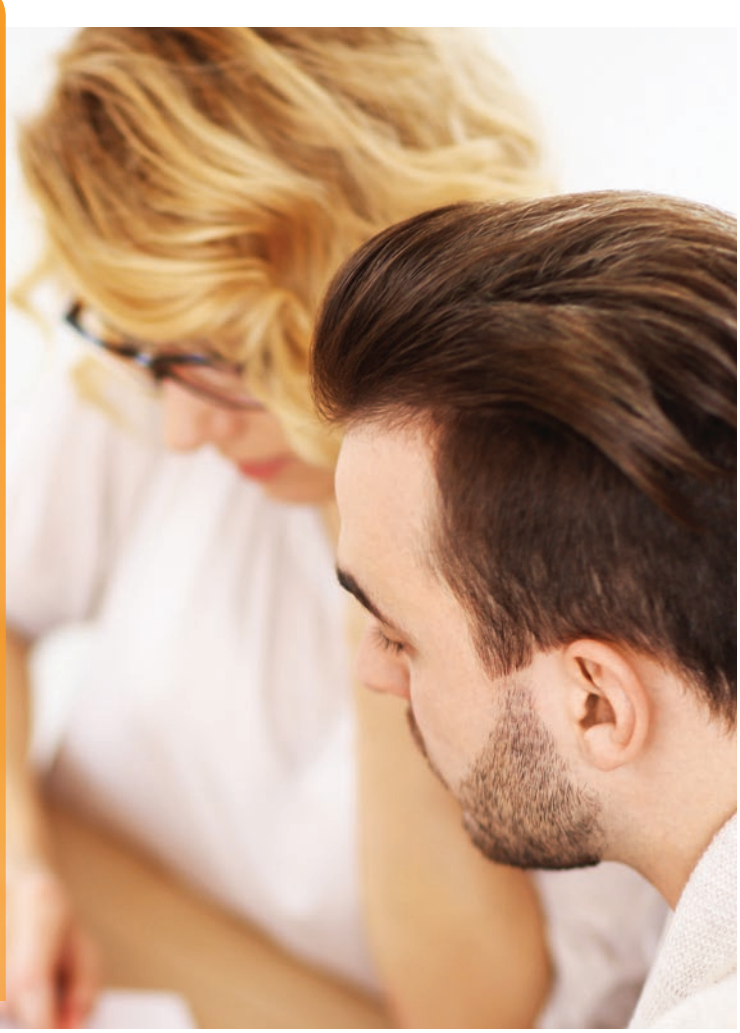
For families with more than three children under age 21:

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

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

Checklist for Easier Enrollment

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



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

If you do not have online access, you can get a paper copy of any Summary of Benefits free of charge by calling toll-free **1-855-329-0690** (TTY/TDD 711).

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

Plan Available in These Counties:

Allegheny, Beaver, Butler, Erie, Washington, Westmoreland

my Connect Blue EPO 250G a Community Blue Flex Plan

Base Plan ID: 33709PA0690003-01

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

Gold

	Preferred	Enhanced	Standard
Deductible (Individual) Cross Accumulates*	$250	$750	$2,250
Deductible (Family)[3] Cross Accumulates*	$500	$1,500	$4,500
Out-of-Pocket Maximum (Individual)[4]	$6,500 All Tiers Combined		
Out-of-Pocket Maximum (Family)[4]	$13,000 All Tiers Combined		
Coinsurance	10% after deductible	30% after deductible	50% after deductible
Primary Care Physician Office Visit	$10 copay	$40 copay	50% after deductible
Specialist Office Visit	$60 copay	$85 copay	50% after deductible
Urgent Care Office Visit	$80 copay	$80 copay	50% after deductible
Emergency Room Visit	$600 copay waived if admitted		
Ambulance Services	10% after preferred deductible		
Inpatient Hospital	$500 copay per day, 3 day max	$1,000 copay per day, 3 day max	50% after deductible
Outpatient Surgery	Non-Hospital: 0% after deductible/ Hospital: $200 copay after deductible	30% after deductible	50% after deductible
Maternity Services	$500 copay per day, 3 day max	$1,000 copay per day, 3 day max	50% after deductible
Diagnostic Lab[5]	Non-Hospital: $25 copay/ Hospital: $50 copay	$75 copay	50% after deductible
Imaging (Basic)[6]	Non-Hospital: $25 copay/ Hospital: $50 copay	$75 copay	50% after deductible
Imaging (Advanced)[7]	Non-Hospital: $50 copay/ Hospital: $100 copay	$300 copay	50% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	$40 copay	$85 copay	50% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period		
Chiropractor	$60 copay	$85 copay	50% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period		
Skilled Nursing Facility Care	10% after deductible	10% after deductible	50% after deductible
Inpatient Mental Health	$500 copay per day, 3 day max	$500 copay per day, 3 day max	$500 copay per day, 3 day max
Outpatient Mental Health	$60 copay	$60 copay	$60 copay
Inpatient Substance Abuse Rehab	$500 copay per day, 3 day max	$500 copay per day, 3 day max	$500 copay per day, 3 day max
Inpatient Substance Abuse Detox	$500 copay per day, 3 day max	$500 copay per day, 3 day max	$500 copay per day, 3 day max
Outpatient Substance Abuse	$60 copay	$60 copay	$60 copay
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0%		
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 50%		

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	15% of the cost of the drug ($3 min/$10 max)	25% of the cost of the drug ($20 min/$75 max)	35% of the cost of the drug ($70 min/$250 max)	50% of the cost of the drug ($150 min/$1,000 max)
Prescription Drug Coverage — Mail (90 Days Supply)	15% of the cost of the drug ($6 min/$20 max)	25% of the cost of the drug ($40 min/$150 max)	35% of the cost of the drug ($140 min/$500 max)	50% of the cost of the drug ($300 min/$2,000 max)

Plan Available in These Counties:

Allegheny, Beaver, Butler, Erie, Washington, Westmoreland

my Connect Blue EPO 1000G a Community Blue Flex Plan

Base Plan ID: 33709PA0690005-00

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

Gold

	Preferred	Enhanced	Standard
Deductible (Individual) Cross Accumulates*	$1,000	$1,500	$2,500
Deductible (Family)[3] Cross Accumulates*	$2,000	$3,000	$5,000
Out-of-Pocket Maximum (Individual)[4]	$6,500 All Tiers Combined		
Out-of-Pocket Maximum (Family)[4]	$13,000 All Tiers Combined		
Coinsurance	10% after deductible	30% after deductible	50% after deductible
Primary Care Physician Office Visit	$10 copay	$40 copay	50% after deductible
Specialist Office Visit	$30 copay	$55 copay	50% after deductible
Urgent Care Office Visit	$80 copay	$80 copay	50% after deductible
Emergency Room Visit	$200 copay (waived if admitted)		
Ambulance Services	10% after preferred deductible		
Inpatient Hospital	$300 copay per day, 3 day max	$800 copay per day, 3 day max	50% after deductible
Outpatient Surgery	Non-Hospital: 0% after deductible/Hospital: $200 copay after deductible	30% after deductible	50% after deductible
Maternity Services	$300 copay per day, 3 day max	$800 copay per day, 3 day max	50% after deductible
Diagnostic Lab[5]	Non-Hospital: $15 copay/ Hospital: $30 copay	$55 copay	50% after deductible
Imaging (Basic)[6]	Non-Hospital: $15 copay/ Hospital: $30 copay	$55 copay	50% after deductible
Imaging (Advanced)[7]	Non-Hospital: $40 copay/ Hospital: $80 copay	$165 copay	50% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	$30 copay	$55 copay	50% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period		
Chiropractor	$30 copay	$55 copay	50% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period		
Skilled Nursing Facility Care	10% after deductible	10% after deductible	50% after deductible
Inpatient Mental Health	$300 copay per day, 3 day max	$300 copay per day, 3 day max	$300 copay per day, 3 day max
Outpatient Mental Health	$30 copay	$30 copay	$30 copay
Inpatient Substance Abuse Rehab	$300 copay per day, 3 day max	$300 copay per day, 3 day max	$300 copay per day, 3 day max
Inpatient Substance Abuse Detox	$300 copay per day, 3 day max	$300 copay per day, 3 day max	$300 copay per day, 3 day max
Outpatient Substance Abuse	$30 copay	$30 copay	$30 copay
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0%		
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 50%		

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	15% of the cost of the drug ($3 min/$10 max)	25% of the cost of the drug ($20 min/$75 max)	35% of the cost of the drug ($70 min/$250 max)	50% of the cost of the drug ($150 min/$1,000 max)
Prescription Drug Coverage — Mail (90 Days Supply)	15% of the cost of the drug ($6 min/$20 max)	25% of the cost of the drug ($40 min/$150 max)	35% of the cost of the drug ($140 min/$500 max)	50% of the cost of the drug ($300 min/$2,000 max)

Plan Available in These Counties:

Allegheny, Beaver, Butler, Erie, Washington, Westmoreland

my Connect Blue EPO 1750S a Community Blue Flex Plan

Base Plan ID: 33709PA0690001-01

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

Silver

	Preferred	Enhanced	Standard
Deductible (Individual) Cross Accumulates*	$1,750	$4,500	$6,000
Deductible (Family)[3] Cross Accumulates*	$3,500	$9,000	$12,000
Out-of-Pocket Maximum (Individual)[4]	$6,900 All Tiers Combined		
Out-of-Pocket Maximum (Family)[4]	$13,800 All Tiers Combined		
Coinsurance	30% after deductible	50% after deductible	60% after deductible
Primary Care Physician Office Visit	$60 copay	$95 copay	60% after deductible
Specialist Office Visit	$100 copay	$140 copay	60% after deductible
Urgent Care Office Visit	$140 copay	$140 copay	60% after deductible
Emergency Room Visit	$500 copay waived if admitted		
Ambulance Services	30% after preferred deductible		
Inpatient Hospital	$1,250 copay per day, 3 day max	$1,750 copay per day, 3 day max	60% after deductible
Outpatient Surgery	Non-Hospital: 0% after deductible/Hospital: $1,000 copay after deductible	50% after deductible	60% after deductible
Maternity Services	$1,250 copay per day, 3 day max	$1,750 copay per day, 3 day max	60% after deductible
Diagnostic Lab[5]	Non-Hospital: $50 copay/ Hospital: $100 copay	$140 copay	60% after deductible
Imaging (Basic)[6]	Non-Hospital: $50 copay/ Hospital: $100 copay	$140 copay	60% after deductible
Imaging (Advanced)[7]	Non-Hospital: $175 copay/ Hospital: $350 copay	$500 copay	60% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	$100 copay	$140 copay	60% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period		
Chiropractor	$100 copay	$140 copay	60% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period		
Skilled Nursing Facility Care	30% after deductible	30% after deductible	60% after deductible
Inpatient Mental Health	$1,250 copay per day, 3 day max	$1,250 copay per day, 3 day max	$1,250 copay per day, 3 day max
Outpatient Mental Health	$100 copay	$100 copay	$100 copay
Inpatient Substance Abuse Rehab	$1,250 copay per day, 3 day max	$1,250 copay per day, 3 day max	$1,250 copay per day, 3 day max
Inpatient Substance Abuse Detox	$1,250 copay per day, 3 day max	$1,250 copay per day, 3 day max	$1,250 copay per day, 3 day max
Outpatient Substance Abuse	$100 copay	$100 copay	$100 copay
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0%		
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 50%		

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	15% of the cost of the drug ($3 min/$10 max)	25% of the cost of the drug ($20 min/$75 max)	35% of the cost of the drug ($70 min/$250 max)	50% of the cost of the drug ($150 min/$1,000 max)
Prescription Drug Coverage — Mail (90 Days Supply)	15% of the cost of the drug ($6 min/$20 max)	25% of the cost of the drug ($40 min/$150 max)	35% of the cost of the drug ($140 min/$500 max)	50% of the cost of the drug ($300 min/$2,000 max)

Plan Available in These Counties:

Allegheny, Beaver, Butler, Washington, Westmoreland, Erie

my Connect Blue EPO 2500S a Community Blue Flex Plan

Base Plan ID: 33709PA0690001-01

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

Gold

	Preferred	Enhanced	Standard
Deductible (Individual) Cross Accumulates*	$2,500	$4,000	$6,000
Deductible (Family)[3] Cross Accumulates*	$5,000	$8,000	$12,000
Out-of-Pocket Maximum (Individual)[4]	$7,150 All Tiers Combined		
Out-of-Pocket Maximum (Family)[4]	$14,300 All Tiers Combined		
Coinsurance	10% after deductible	30% after deductible	50% after deductible
Primary Care Physician Office Visit	$55 copay	$75 copay	50% after deductible
Specialist Office Visit	$70 copay	$120 copay	50% after deductible
Urgent Care Office Visit	$100 copay	$100 copay	50% after deductible
Emergency Room Visit	$500 copay waived if admitted		
Ambulance Services	10% after preferred deductible		
Inpatient Hospital	$500 copay per day, 3 day max	$1,000 copay per day, 3 day max	50% after deductible
Outpatient Surgery	Non-Hospital: 0% after deductible/Hospital: $1,000 copay after deductible	30% after deductible	50% after deductible
Maternity Services	$500 copay per day, 3 day max	$1,000 copay per day, 3 day max	50% after deductible
Diagnostic Lab[5]	Non-Hospital: $35 copay/ Hospital: $70 copay	$120 copay	50% after deductible
Imaging (Basic)[6]	Non-Hospital: $35 copay/ Hospital: $70 copay	$120 copay	50% after deductible
Imaging (Advanced)[7]	Non-Hospital: $150 copay/ Hospital: $300 copay	$500 copay	50% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	$70 copay	$120 copay	50% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period		
Chiropractor	$70 copay	$120 copay	50% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period		
Skilled Nursing Facility Care	10% after deductible	10% after deductible	50% after deductible
Inpatient Mental Health	$500 copay per day, 3 day max	$500 copay per day, 3 day max	$500 copay per day, 3 day max
Outpatient Mental Health	$70 copay	$70 copay	$70 copay
Inpatient Substance Abuse Rehab	$500 copay per day, 3 day max	$500 copay per day, 3 day max	$500 copay per day, 3 day max
Inpatient Substance Abuse Detox	$500 copay per day, 3 day max	$500 copay per day, 3 day max	$500 copay per day, 3 day max
Outpatient Substance Abuse	$70 copay	$70 copay	$70 copay
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0%		
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 50%		

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	15% of the cost of the drug ($3 min/$10 max)	25% of the cost of the drug ($20 min/$75 max)	35% of the cost of the drug ($70 min/$250 max)	50% of the cost of the drug ($150 min/$1,000 max)
Prescription Drug Coverage — Mail (90 Days Supply)	15% of the cost of the drug ($6 min/$20 max)	25% of the cost of the drug ($40 min/$150 max)	35% of the cost of the drug ($140 min/$500 max)	50% of the cost of the drug ($300 min/$2,000 max)

Plan Available in These Counties:

Allegheny, Beaver, Butler, Erie, Washington, Westmoreland

my Connect Blue EPO 6500B a Community Blue Flex Plan

Base Plan ID: 33709PA0690004-01

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

Bronze

	Preferred	Enhanced	Standard
Deductible (Individual) Cross Accumulates*	$6,500	$6,800	$7,000
Deductible (Family)[3] Cross Accumulates*	$13,000	$13,600	$14,000
Out-of-Pocket Maximum (Individual)[4]	$7,150 All Tiers Combined		
Out-of-Pocket Maximum (Family)[4]	$14,300 All Tiers Combined		
Coinsurance	30% after deductible	50% after deductible	60% after deductible
Primary Care Physician Office Visit	$90 copay	$130 copay	60% after deductible
Specialist Office Visit	$120 copay	$180 copay	60% after deductible
Urgent Care Office Visit	$130 copay	$130 copay	60% after deductible
Emergency Room Visit	30% after preferred deductible waived if admitted		
Ambulance Services	30% after preferred deductible		
Inpatient Hospital	$1,500 copay per admission	50% after deductible	60% after deductible
Outpatient Surgery	30% after deductible	50% after deductible	60% after deductible
Maternity Services	$1,500 copay per admission	50% after deductible	60% after deductible
Diagnostic Lab[5]	Non-Hospital: $40 copay/ Hospital: $80 copay	$130 copay	60% after deductible
Imaging (Basic)[6]	Non-Hospital: $40 copay/ Hospital: $80 copay	$130 copay	60% after deductible
Imaging (Advanced)[7]	30% after deductible	50% after deductible	60% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	30% after deductible	50% after deductible	60% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period		
Chiropractor	$120 copay	$180 copay	60% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period		
Skilled Nursing Facility Care	30% after deductible	30% after deductible	60% after deductible
Inpatient Mental Health	$1,500 copay per admission	$1,500 copay per admission	$1,500 copay per admission
Outpatient Mental Health	$120 copay	$120 copay	$120 copay
Inpatient Substance Abuse Rehab	$1,500 copay per admission	$1,500 copay per admission	$1,500 copay per admission
Inpatient Substance Abuse Detox	$1,500 copay per admission	$1,500 copay per admission	$1,500 copay per admission
Outpatient Substance Abuse	$120 copay	$120 copay	$120 copay
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0%		
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 50%		

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	15% of the cost of the drug ($3 min/$10 max)	25% of the cost of the drug ($20 min/$75 max)	35% of the cost of the drug ($70 min/$250 max)	50% of the cost of the drug ($150 min/$1,000 max)
Prescription Drug Coverage — Mail (90 Days Supply)	15% of the cost of the drug ($6 min/$20 max)	25% of the cost of the drug ($40 min/$150 max)	35% of the cost of the drug ($140 min/$500 max)	50% of the cost of the drug ($300 min/$2,000 max)

Plan Available in These Counties:

Bedford, Blair, Cambria, McKean, Somerset, Venango

my Community Blue Flex PPO 1700GQ[11]

Base Plan ID: 33709PA0700005-01

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

Gold

	Enhanced	Standard
Deductible (Individual)	$1,700 All Tiers Combined	
Deductible (Family)[1]	$3,400 All Tiers Combined	
Out-of-Pocket Maximum (Individual)[4]	$3,250 All Tiers Combined	
Out-of-Pocket Maximum (Family)[4]	$6,500 All Tiers Combined	
Coinsurance	10% after deductible	30% after deductible
Primary Care Physician Office Visit	10% after deductible	30% after deductible
Specialist Office Visit	10% after deductible	30% after deductible
Urgent Care Office Visit	10% after deductible	30% after deductible
Emergency Room Visit	10% after enhanced deductible	
Ambulance Services	10% after enhanced deductible	
Inpatient Hospital	10% after deductible	30% after deductible
Outpatient Surgery	10% after deductible	30% after deductible
Maternity Services	10% after deductible	30% after deductible
Diagnostic Lab[5]	10% after deductible	30% after deductible
Imaging (Basic)[6]	10% after deductible	30% after deductible
Imaging (Advanced)[7]	10% after deductible	30% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	10% after deductible	30% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period	
Chiropractor	10% after deductible	30% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period	
Skilled Nursing Facility Care	10% after deductible	30% after deductible
Inpatient Mental Health	10% after deductible	10% after deductible
Outpatient Mental Health	10% after deductible	10% after deductible
Inpatient Substance Abuse Rehab	10% after deductible	10% after deductible
Inpatient Substance Abuse Detox	10% after deductible	10% after deductible
Outpatient Substance Abuse	10% after deductible	10% after deductible
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0% after deductible	
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 10% after deductible	

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Prescription Drug Coverage — Mail (90 Days Supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible

Plan Available in These Counties:

Bedford, Blair, Cambria, McKean, Somerset, Venango

my Community Blue Flex PPO 2100S

Base Plan ID: 33709PA0700007-01

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

Silver

	Enhanced	Standard
Deductible (Individual) Cross Accumulates*	$2,100	$4,500
Deductible (Family)[3] Cross Accumulates*	$4,200	$9,000
Out-of-Pocket Maximum (Individual)[4]	$6,900 All Tiers Combined	
Out-of-Pocket Maximum (Family)[4]	$13,800 All Tiers Combined	
Coinsurance	10% after deductible	40% after deductible
Primary Care Physician Office Visit	$60 copay	40% after deductible
Specialist Office Visit	$80 copay	40% after deductible
Urgent Care Office Visit	$100 copay	40% after deductible
Emergency Room Visit	$500 copay after enhanced deductible	
Ambulance Services	10% after enhanced deductible	
Inpatient Hospital	$1,000 copay (per admission) after deductible	40% after deductible
Outpatient Surgery	10% after deductible	40% after deductible
Maternity Services	$1,000 copay (per admission) after deductible	40% after deductible
Diagnostic Lab[5]	Non-Hospital: $40 copay/Hospital: $80 copay	40% after deductible
Imaging (Basic)[6]	$80 copay	40% after deductible
Imaging (Advanced)[7]	$300 copay	40% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	$80 copay	40% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period	
Chiropractor	$80 copay	40% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period	
Skilled Nursing Facility Care	$500 copay after deductible	40% after deductible
Inpatient Mental Health	$1,000 copay (per admission) after deductible	$1,000 copay (per admission) after deductible
Outpatient Mental Health	$80 copay	$80 copay
Inpatient Substance Abuse Rehab	$1,000 copay (per admission) after deductible	$1,000 copay (per admission) after deductible
Inpatient Substance Abuse Detox	$1,000 copay (per admission) after deductible	$1,000 copay (per admission) after deductible
Outpatient Substance Abuse	$80 copay	$80 copay
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0%	
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 50%	

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	15% of the cost of the drug ($3 min/$10 max)	25% of the cost of the drug ($20 min/$75 max)	35% of the cost of the drug ($70 min/$250 max)	50% of the cost of the drug ($150 min/$1,000 max)
Prescription Drug Coverage — Mail (90 Days Supply)	15% of the cost of the drug ($6 min/$20 max)	25% of the cost of the drug ($40 min/$150 max)	35% of the cost of the drug ($140 min/$500 max)	50% of the cost of the drug ($300 min/$2,000 max)

Plan Available in These Counties:

Bedford, Blair, Cambria, McKean, Somerset, Venango

my Community Blue Flex PPO 2800SQE[11]

Base Plan ID: 33709PA0700006-01

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

Silver

	Enhanced	Standard
Deductible (Individual)	$2,800 All Tiers Combined	
Deductible (Family)[2]	$5,600 All Tiers Combined	
Out-of-Pocket Maximum (Individual)[4]	$5,900 All Tiers Combined	
Out-of-Pocket Maximum (Family)[4]	$11,800 All Tiers Combined	
Coinsurance	20% after deductible	40% after deductible
Primary Care Physician Office Visit	20% after deductible	40% after deductible
Specialist Office Visit	20% after deductible	40% after deductible
Urgent Care Office Visit	20% after deductible	40% after deductible
Emergency Room Visit	20% after enhanced deductible	
Ambulance Services	20% after enhanced deductible	
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Maternity Services	20% after deductible	40% after deductible
Diagnostic Lab[5]	20% after deductible	40% after deductible
Imaging (Basic)[6]	20% after deductible	40% after deductible
Imaging (Advanced)[7]	20% after deductible	40% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	20% after deductible	40% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period	
Chiropractor	20% after deductible	40% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period	
Skilled Nursing Facility Care	20% after deductible	40% after deductible
Inpatient Mental Health	20% after deductible	20% after deductible
Outpatient Mental Health	20% after deductible	20% after deductible
Inpatient Substance Abuse Rehab	20% after deductible	20% after deductible
Inpatient Substance Abuse Detox	20% after deductible	20% after deductible
Outpatient Substance Abuse	20% after deductible	20% after deductible
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0% after deductible	
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 20% after deductible	

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription Drug Coverage — Mail (90 Days Supply)	20% after deductible	20% after deductible	20% after deductible	20% after deductible

Plan Available in These Counties:

Bedford, Blair, Cambria, McKean, Somerset, Venango

my Community Blue Flex PPO 6800B

Base Plan ID: 33709PA0700008-01

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

Bronze

	Enhanced	Standard
Deductible (Individual)	$6,800 All Tiers Combined	
Deductible (Family)[3]	$13,600 All Tiers Combined	
Out-of-Pocket Maximum (Individual)[4]	$7,150 All Tiers Combined	
Out-of-Pocket Maximum (Family)[4]	$14,300 All Tiers Combined	
Coinsurance	30% after deductible	60% after deductible
Primary Care Physician Office Visit	$95 copay	$130 copay
Specialist Office Visit	$130 copay	$160 copay
Urgent Care Office Visit	$150 copay	$190 copay
Emergency Room Visit	30% after enhanced deductible	
Ambulance Services	30% after enhanced deductible	
Inpatient Hospital	30% after deductible	60% after deductible
Outpatient Surgery	30% after deductible	60% after deductible
Maternity Services	30% after deductible	60% after deductible
Diagnostic Lab[5]	Non-Hospital: $50 copay/ Hospital: $95 copay	$135 copay
Imaging (Basic)[6]	$95 copay	$135 copay
Imaging (Advanced)[7]	30% after deductible	60% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	30% after deductible	60% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period	
Chiropractor	$130 copay	$160 copay
Chiropractor Limits	Limit: 20 visits per benefit period	
Skilled Nursing Facility Care	30% after deductible	60% after deductible
Inpatient Mental Health	30% after deductible	30% after deductible
Outpatient Mental Health	$125 copay	$125 copay
Inpatient Substance Abuse Rehab	30% after deductible	30% after deductible
Inpatient Substance Abuse Detox	30% after deductible	30% after deductible
Outpatient Substance Abuse	$125 copay	$125 copay
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0%	
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 50%	

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	15% of the cost of the drug ($3 min/$10 max)	25% of the cost of the drug ($20 min/$75 max)	35% of the cost of the drug ($70 min/$250 max)	50% of the cost of the drug ($150 min/$1,000 max)
Prescription Drug Coverage — Mail (90 Days Supply)	15% of the cost of the drug ($6 min/$20 max)	25% of the cost of the drug ($40 min/$150 max)	35% of the cost of the drug ($140 min/$500 max)	50% of the cost of the drug ($300 min/$2,000 max)

Plan Available in These Counties:

Allegheny, Beaver, Bedford, Blair, Butler, Cambria, Erie, McKean, Somerset, Venango, Washington, Westmoreland

Comprehensive Care Flex Blue PPO 500

Base Plan ID: 70194PA0160003-01

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

Platinum

	Enhanced	Standard
Deductible (Individual) Cross Accumulates*	$500	$1,300
Deductible (Family)[3] Cross Accumulates*	$1,000	$2,600
Out-of-Pocket Maximum (Individual)[4]	$1,800 All Tiers Combined	
Out-of-Pocket Maximum (Family)[4]	$3,600 All Tiers Combined	
Coinsurance	10% after deductible	40% after deductible
Primary Care Physician Office Visit	10% after deductible	40% after deductible
Specialist Office Visit	10% after deductible	40% after deductible
Urgent Care Office Visit	10% after deductible	40% after deductible
Emergency Room Visit	10% after enhanced deductible	
Ambulance Services	10% after enhanced deductible	
Inpatient Hospital	10% after deductible	40% after deductible
Outpatient Surgery	10% after deductible	40% after deductible
Maternity Services	10% after deductible	40% after deductible
Diagnostic Lab[5]	10% after deductible	40% after deductible
Imaging (Basic)[6]	10% after deductible	40% after deductible
Imaging (Advanced)[7]	10% after deductible	40% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	10% after deductible	40% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period	
Chiropractor	10% after deductible	40% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period	
Skilled Nursing Facility Care	10% after deductible	40% after deductible
Inpatient Mental Health	10% after deductible	10% after deductible
Outpatient Mental Health	10% after deductible	10% after deductible
Inpatient Substance Abuse Rehab	10% after deductible	10% after deductible
Inpatient Substance Abuse Detox	10% after deductible	10% after deductible
Outpatient Substance Abuse	10% after deductible	10% after deductible
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0%	
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 50%	

Prescription Formulary	HCR Comprehensive Formulary[10]				
	Formulary Generic	Formulary Brand	Non-Formulary Generic and Brand	Formulary Specialty	Non-Formulary Specialty
Prescription Drug Coverage — Retail (31 Day Supply)	$5 Copay	$20 Copay	$45 Copay	50% coinsurance ($500 max)	50% coinsurance ($750 max)
Prescription Drug Coverage — Mail (90 Days Supply)	$10 Copay	$40 Copay	$90 Copay	50% coinsurance ($1,000 max)	50% coinsurance ($1,500 max)

Plan Available in These Counties:

Allegheny, Beaver, Bedford, Blair, Butler, Cambria, Erie, McKean, Somerset, Venango, Washington, Westmoreland

Health Savings Blue PPO 1700

Base Plan ID: 70194PA0150005-01

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

Gold

	Plan Benefits
Deductible (Individual)	$1,700
Deductible (Family)[1]	$3,400
Out-of-Pocket Maximum (Individual)[4]	$3,250
Out-of-Pocket Maximum (Family)[4]	$6,500
Coinsurance	10% after deductible
Primary Care Physician Office Visit	10% after deductible
Specialist Office Visit	10% after deductible
Urgent Care Office Visit	10% after deductible
Emergency Room Visit	10% after deductible
Ambulance Services	10% after deductible
Inpatient Hospital	10% after deductible
Outpatient Surgery	10% after deductible
Maternity Services	10% after deductible
Diagnostic Lab[5]	10% after deductible
Imaging (Basic)[6]	10% after deductible
Imaging (Advanced)[7]	10% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	10% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period
Chiropractor	10% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period
Skilled Nursing Facility Care	10% after deductible
Inpatient Mental Health	10% after deductible
Outpatient Mental Health	10% after deductible
Inpatient Substance Abuse Rehab	10% after deductible
Inpatient Substance Abuse Detox	10% after deductible
Outpatient Substance Abuse	10% after deductible
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0% after deductible
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 0% after deductible

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Prescription Drug Coverage — Mail (90 Days Supply)	10% after deductible	10% after deductible	10% after deductible	10% after deductible

Plan Available in These Counties:

Allegheny, Beaver, Bedford, Blair, Butler, Cambria, Erie, McKean, Somerset, Venango, Washington, Westmoreland

Health Savings Blue PPO Embedded 2700[11]

Base Plan ID: 70194PA0150003-01

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

Silver

	Plan Benefits
Deductible (Individual)	$2,700
Deductible (Family)[2]	$5,400
Out-of-Pocket Maximum (Individual)[4]	$6,500
Out-of-Pocket Maximum (Family)[4]	$13,000
Coinsurance	20% after deductible
Primary Care Physician Office Visit	20% after deductible
Specialist Office Visit	20% after deductible
Urgent Care Office Visit	20% after deductible
Emergency Room Visit	20% after deductible
Ambulance Services	20% after deductible
Inpatient Hospital	20% after deductible
Outpatient Surgery	20% after deductible
Maternity Services	20% after deductible
Diagnostic Lab[5]	20% after deductible
Imaging (Basic)[6]	20% after deductible
Imaging (Advanced)[7]	20% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	20% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period
Chiropractor	20% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period
Skilled Nursing Facility Care	20% after deductible
Inpatient Mental Health	20% after deductible
Outpatient Mental Health	20% after deductible
Inpatient Substance Abuse Rehab	20% after deductible
Inpatient Substance Abuse Detox	20% after deductible
Outpatient Substance Abuse	20% after deductible
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0% after deductible
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 20% after deductible

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Day Supply)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription Drug Coverage — Mail (90 Days Supply)	20% after deductible	20% after deductible	20% after deductible	20% after deductible

Plan Available in These Counties:

Allegheny, Beaver, Bedford, Blair, Butler, Cambria, Erie, McKean, Somerset, Venango, Washington, Westmoreland

Major Events Blue PPO 7150 a Community Blue Plan

Base Plan ID: 33709PA0380004-01

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

Catastrophic

	Plan Benefits
Deductible (Individual)	$7,150
Deductible (Family)[3]	$14,300
Out-of-Pocket Maximum (Individual)[4]	$7,150
Out-of-Pocket Maximum (Family)[4]	$14,300
Coinsurance	0% after deductible
Primary Care Physician Office Visit	0% after deductible - Eligible for 3 visits prior to deductible at no cost
Specialist Office Visit	0% after deductible
Urgent Care Office Visit	0% after deductible
Emergency Room Visit	0% after deductible
Ambulance Services	0% after deductible
Inpatient Hospital	0% after deductible
Outpatient Surgery	0% after deductible
Maternity Services	0% after deductible
Diagnostic Lab[5]	0% after deductible
Imaging (Basic)[6]	0% after deductible
Imaging (Advanced)[7]	0% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	0% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period
Chiropractor	0% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period
Skilled Nursing Facility Care	0% after deductible
Inpatient Mental Health	0% after deductible
Outpatient Mental Health	0% after deductible
Inpatient Substance Abuse Rehab	0% after deductible
Inpatient Substance Abuse Detox	0% after deductible
Outpatient Substance Abuse	0% after deductible
Pediatric Vision Services[8]	Exam: 0% after deductible; Frames/Lenses: 0% after deductible
Pediatric Dental Services[8]	Exam/Cleaning: 0% after deductible; Basic Restorative Services: 0% after deductible

Prescription Formulary	HCR Comprehensive[10]		
	Generic	Brand Formulary	Non-Formulary
Prescription Drug Coverage — Retail (31 Days Supply)	0% after deductible	0% after deductible	0% after deductible
Prescription Drug Coverage — Mail (90 Days Supply)	0% after deductible	0% after deductible	0% after deductible

Highmark health insurance plans are offered with or without financial help*.

The following three plan options may be purchased directly through Highmark without financial help in select Pennsylvania counties.

*Highmark plans listed on pages 8-20 are offered with financial help through the Health Insurance Marketplace (HealthCare.gov). Financial help is only available with plans purchased through the Health Insurance Marketplace. These plans are also available directly through Highmark without financial help.

Highmark Blue Edge Dental Available

Do you need adult dental insurance? Highmark Blue Edge Dental offers a level of coverage that will fit your budget. Visit **HighmarkBlueEdgeDental.com** to find out more.

Plan Available in These Counties:

Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cameron, Cambria, Centre*, Clearfield, Clarion, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Washington, Warren, Westmoreland

Shared Cost Blue PPO 6800

*Note: You must reside in one of the following zip codes in Centre County to enroll in this plan – 16677, 16686, 16829, 16845, 16859, 16865, 16866, 16874, 16877.

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

Bronze

	Plan Benefits
Deductible (Individual)	$6,800
Deductible (Family)[3]	$13,600
Out-of-Pocket Maximum (Individual)[4]	$7,150
Out-of-Pocket Maximum (Family)[4]	$14,300
Coinsurance	30% after deductible
Primary Care Physician Office Visit	$100 copay
Specialist Office Visit	$135 copay
Urgent Care Office Visit	$150 copay
Emergency Room Visit	30% after deductible
Ambulance Services	30% after deductible
Inpatient Hospital	30% after deductible
Outpatient Surgery	30% after deductible
Maternity Services	30% after deductible
Diagnostic Lab[5]	$95 copay
Imaging (Basic)[6]	$95 copay
Imaging (Advanced)[7]	30% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	30% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period
Chiropractor	$135 copay
Chiropractor Limits	Limit: 20 visits per benefit period
Skilled Nursing Facility Care	30% after deductible
Inpatient Mental Health	30% after deductible
Outpatient Mental Health	$125 copay
Inpatient Substance Abuse Rehab	30% after deductible
Inpatient Substance Abuse Detox	30% after deductible
Outpatient Substance Abuse	$125 copay
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0%
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 50%

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	15% of the cost of the drug ($3 min/$10 max)	25% of the cost of the drug ($20 min/$75 max)	35% of the cost of the drug ($70 min/$250 max)	50% of the cost of the drug ($150 min/$1,000 max)
Prescription Drug Coverage — Mail (90 Days Supply)	15% of the cost of the drug ($6 min/$20 max)	25% of the cost of the drug ($40 min/$150 max)	35% of the cost of the drug ($140 min/$500 max)	50% of the cost of the drug ($300 min/$2,000 max)

Plan Available in These Counties:

Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cameron, Cambria, Centre*, Clearfield, Clarion, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Washington, Warren, Westmoreland

Care Guide Blue HMO 750

*Note: You must reside in one of the following zip codes in Centre County to enroll in this plan – 16677, 16686, 16829, 16845, 16859, 16865, 16866, 16874, 16877.

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

Gold

	Plan Benefits
Deductible (Individual)	$750
Deductible (Family)[3]	$1,500
Out-of-Pocket Maximum (Individual)[4]	$5,750
Out-of-Pocket Maximum (Family)[4]	$11,500
Coinsurance	20% after deductible
Primary Care Physician Office Visit	$15 copay
Specialist Office Visit	$50 copay
Urgent Care Office Visit	$60 copay
Emergency Room Visit	$250 copay
Ambulance Services	$50 copay
Inpatient Hospital	20% after deductible
Outpatient Surgery	20% after deductible
Maternity Services	20% after deductible
Diagnostic Lab[5]	$20 copay
Imaging (Basic)[6]	$50 copay
Imaging (Advanced)[7]	$100 copay
Therapy and Rehab Services (Rehabilitative & Habilitative)	$50 copay
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period
Chiropractor	$50 copay
Chiropractor Limits	Limit: 20 visits per benefit period
Skilled Nursing Facility Care	20% after deductible
Inpatient Mental Health	20% after deductible
Outpatient Mental Health	$50 copay
Inpatient Substance Abuse Rehab	20% after deductible
Inpatient Substance Abuse Detox	20% after deductible
Outpatient Substance Abuse	$50 copay
Pediatric Vision Services[8]	Exam: 0%; Frames/Lenses: 0%
Pediatric Dental Services[8]	Exam/Cleaning: 0%; Basic Restorative Services: 50%

Prescription Formulary	Essential Formulary[9]			
	Tier 1	Tier 2	Tier 3	Tier 4
Prescription Drug Coverage — Retail (31 Days Supply)	15% of the cost of the drug ($3 min/$10 max)	25% of the cost of the drug ($20 min/$75 max)	35% of the cost of the drug ($70 min/$250 max)	50% of the cost of the drug ($150 min/$1,000 max)
Prescription Drug Coverage — Mail (90 Days Supply)	15% of the cost of the drug ($6 min/$20 max)	25% of the cost of the drug ($40 min/$150 max)	35% of the cost of the drug ($140 min/$500 max)	50% of the cost of the drug ($300 min/$2,000 max)

Plan Available in These Counties:

Armstrong, Cameron, Centre*, Clarion, Clearfield, Crawford, Elk, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, Mercer, Potter, Warren

Major Events Blue PPO 7150 a Community Blue Plan

Note: You must reside in one of the following zip codes in Centre County to enroll in this plan – 16677, 16686, 16829, 16845, 16859, 16865, 16866, 16874, 16877.

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

Catastrophic

	Plan Benefits
Deductible (Individual)	$7,150
Deductible (Family)[3]	$14,300
Out-of-Pocket Maximum (Individual)[4]	$7,150
Out-of-Pocket Maximum (Family)[4]	$14,300
Coinsurance	0% after deductible
Primary Care Physician Office Visit	0% after deductible - Eligible for 3 visits prior to deductible at no cost
Specialist Office Visit	0% after deductible
Urgent Care Office Visit	0% after deductible
Emergency Room Visit	0% after deductible
Ambulance Services	0% after deductible
Inpatient Hospital	0% after deductible
Outpatient Surgery	0% after deductible
Maternity Services	0% after deductible
Diagnostic Lab[5]	0% after deductible
Imaging (Basic)[6]	0% after deductible
Imaging (Advanced)[7]	0% after deductible
Therapy and Rehab Services (Rehabilitative & Habilitative)	0% after deductible
Occupational/Speech Therapy Limit	Limit: 30 visits for rehabilitative/30 visits for habilitative per benefit period
Chiropractor	0% after deductible
Chiropractor Limits	Limit: 20 visits per benefit period
Skilled Nursing Facility Care	0% after deductible
Inpatient Mental Health	0% after deductible
Outpatient Mental Health	0% after deductible
Inpatient Substance Abuse Rehab	0% after deductible
Inpatient Substance Abuse Detox	0% after deductible
Outpatient Substance Abuse	0% after deductible
Pediatric Vision Services[8]	Exam: 0% after deductible; Frames/Lenses: 0% after deductible
Pediatric Dental Services[8]	Exam/Cleaning: 0% after deductible; Basic Restorative Services: 0% after deductible

Prescription Formulary	HCR Comprehensive[10]		
	Generic	Brand Formulary	Non-Formulary
Prescription Drug Coverage — Retail (31 Days Supply)	0% after deductible	0% after deductible	0% after deductible
Prescription Drug Coverage — Mail (90 Days Supply)	0% after deductible	0% after deductible	0% after deductible

Highmark Disclosures

Important Benefit Details

*Cross-accumulate means that any in-network costs that you incur when receiving covered services at the Preferred Value, Enhanced Value or Standard Value levels of benefits count toward your Preferred Value, Enhanced Value and your Standard.

[1] **my Community Blue Flex PPO 1700GQ** and **Health Savings Blue PPO 1700** plans are Non-Embedded Familiy Deductible: For an Agreement covering more than one (1) family member, the ENTIRE family deductible must be met within a benefit period (January 1, 2017 – December 31, 2017) before Highmark will pay for covered services for ANY family member. The family deductible can be satisfied by an individual family member or a combination of one or more family members.

[2] **my Community Blue Flex PPO 2800SQE and Health Savings Blue PPO Embedded 2700** are Embedded Family Deductible: For an Agreement covering more than one (1) family member, as each Member satisfies their individual Deductible, the Plan will begin to pay benefits for Covered Services for that Member for the remainder of the Benefit Period (January 1, 2017– December 31, 2017), whether or not the entire family Deductible has been satisfied. When the family Deductible has been satisfied, the family Deductible will be considered to have been satisfied for all remaining covered family members. No individual Member may satisfy the entire family Deductible.

[3] Aggregate Family Deductible: For an Agreement covering more than one (1) family member, as each Member satisfies their individual Deductible, the Plan will begin to pay benefits for Covered Services for that Member for the remainder of the Benefit Period (January 1, 2017– December 31, 2017), whether or not the entire family Deductible has been satisfied. When the family Deductible has been satisfied, the family Deductible will be considered to have been satisfied for all remaining covered family members. 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.

[4] You are responsible for out-of-pocket costs each benefit period (January 1, 2017 – December 31, 2017) up to the maximum amount shown. Thereafter, the plan pays 100% of the Provider's Allowable Charge during the remainder of the benefit period. This amount does not include amounts in excess of the provider's allowable charge.

[5] 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.

[6] 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.

[7] 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.

[8] Pediatric vision benefits utilize the Davis National Network. Pediatric dental benefits utilize United Concordia's Advantage Network.

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

[10] The **Major Events Blue PPO 7150** and **Comprehensive Care Flex Blue PPO 500** plans utilizes the HCR Comprehensive Formulary on the National network. Specialty drug copays may vary. Mail order available.

[11] The **my Community Blue Flex PPO 1700GQ**, **my Community Blue Flex PPO 2800SQE** and **Health Savings Blue PPO Embedded 2700** are Qualified High Deductible Health Plans and may be coupled with a Health Savings Account (HSA). However, certain Cost-Sharing Reductions (CSR) or plan variations of this plan that are offered through the Health Insurance Marketplace are not intended to be used with an HSA. If you have questions, please check with your financial advisor.

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

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

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

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-329-0690 (TTY/TDD 711).

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

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

Access to UPMC Providers who are not network providers for 2017: Highmark members who were in a course of treatment for a chronic or persistent condition in 2013, 2014 or 2015 with a UPMC provider will continue to have in-network access to that provider for treatment of that condition in 2017. Additionally, members who were treated at UPMC Mercy or by a UPMC Mercy physician for a confirmed pregnancy on or before June 30, 2016, may continue to receive treatment at UPMC Mercy through the period of delivery and post-partum care for that pregnancy. To learn more visit DiscoverHighmark.com/ConsentWP. You should confirm the network status of a provider prior to receiving services. You can call My Care Navigator at 1-888-BLUE-428 to confirm if a doctor or facility will be in network in 2017.

Your Health Care Glossary

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

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

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

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

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

- An embedded deductible has two parts: an individual deductible and a family deductible. Each family member can meet but not exceed his/her own deductible before the family deductible is met. (Individual deductibles add up to meet the family deductible.)
- With a non-embedded family deductible, the amount of the deductible can be met by one family member or by a combination of family members. The health plan does not begin to pay for any individual medical expenses until the family deductible is met.

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

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

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

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

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

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

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

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

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

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

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

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

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

Committed to Providing Outstanding Service

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan 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 Plan 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 Plan 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 Plan:

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

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

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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

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

Committed to Providing Outstanding Service

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

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

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

Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-800-876-7639 uffrufe.

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

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

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

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

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

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-800-876-7639 નંબર પર ફોન કરો.

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

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

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-800-876-7639។

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

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

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

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

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-800-876-7639.

BASE RATES FOR YOUR COUNTY

You can find these plans on the Health Insurance Marketplace by using the Highmark Base Plan ID*.

	PLANS AVAILABLE IN ALLEGHENY, BEAVER, BUTLER, WASHINGTON & WESTMORELAND COUNTIES									
	Gold		Gold		Silver		Silver		Bronze	
	my Connect Blue EPO 250G		my Connect Blue EPO 1000G		my Connect Blue EPO 1750S		my Connect Blue EPO 2500S		my Connect Blue EPO 6500B	
Base Plan ID*	33709PA0690003		33709PA0690005		33709PA0690001		33709PA0690002		33709PA0690004	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0 - 20	$190.68	$190.68	$186.10	$186.10	$155.64	$155.64	$157.47	$157.47	$125.86	$125.86
21	$300.28	$307.79	$293.07	$300.40	$245.10	$251.23	$247.98	$254.18	$198.21	$203.17
22	$300.28	$307.79	$293.07	$300.40	$245.10	$251.23	$247.98	$254.18	$198.21	$203.17
23	$300.28	$307.79	$293.07	$300.40	$245.10	$251.23	$247.98	$254.18	$198.21	$203.17
24	$300.28	$307.79	$293.07	$300.40	$245.10	$251.23	$247.98	$254.18	$198.21	$203.17
25	$301.48	$309.02	$294.24	$301.60	$246.08	$252.23	$248.97	$255.19	$199.00	$203.98
26	$307.49	$315.18	$300.10	$307.60	$250.98	$257.25	$253.93	$260.28	$202.97	$208.04
27	$314.69	$322.56	$307.14	$314.82	$256.86	$263.28	$259.88	$266.38	$207.72	$212.91
28	$326.40	$334.56	$318.57	$326.53	$266.42	$273.08	$269.55	$276.29	$215.45	$220.84
29	$336.01	$344.41	$327.95	$336.15	$274.27	$281.13	$277.49	$284.43	$221.80	$227.35
30	$340.82	$349.34	$332.63	$340.95	$278.19	$285.14	$281.46	$288.50	$224.97	$230.59
31	$348.02	$356.72	$339.67	$348.16	$284.07	$291.17	$287.41	$294.60	$229.73	$235.47
32	$355.23	$364.11	$346.70	$355.37	$289.95	$297.20	$293.36	$300.69	$234.48	$240.34
33	$359.74	$368.73	$351.10	$359.88	$293.63	$300.97	$297.08	$304.51	$237.46	$243.40
34	$364.54	$373.65	$355.79	$364.68	$297.55	$304.99	$301.05	$308.58	$240.63	$246.65
35	$366.94	$376.11	$358.13	$367.08	$299.51	$307.00	$303.03	$310.61	$242.21	$248.27
36	$369.34	$378.57	$360.48	$369.49	$301.47	$309.01	$305.02	$312.65	$243.80	$249.90
37	$371.75	$381.04	$362.82	$371.89	$303.43	$311.02	$307.00	$314.68	$245.38	$251.51
38	$374.15	$383.50	$365.17	$374.30	$305.39	$313.02	$308.98	$316.70	$246.97	$253.14
39	$378.95	$388.42	$369.85	$379.10	$309.32	$317.05	$312.95	$320.77	$250.14	$256.39
40	$383.76	$422.14	$374.54	$411.99	$313.24	$344.56	$316.92	$348.61	$253.31	$278.64
41	$390.96	$432.01	$381.58	$421.65	$319.12	$352.63	$322.87	$356.77	$258.07	$285.17
42	$397.87	$442.43	$388.32	$431.81	$324.76	$361.13	$328.57	$365.37	$262.63	$292.04
43	$407.48	$456.79	$397.70	$445.82	$332.60	$372.84	$336.51	$377.23	$268.97	$301.52
44	$419.49	$474.86	$409.42	$463.46	$342.40	$387.60	$346.43	$392.16	$276.90	$313.45
45	$433.60	$496.47	$423.19	$484.55	$353.92	$405.24	$358.08	$410.00	$286.22	$327.72
46	$450.42	$522.49	$439.61	$509.95	$367.65	$426.47	$371.97	$431.49	$297.32	$344.89
47	$469.34	$552.41	$458.07	$539.15	$383.09	$450.90	$387.59	$456.19	$309.80	$364.63
48	$490.96	$587.19	$479.17	$573.09	$400.74	$479.29	$405.45	$484.92	$324.07	$387.59
49	$512.28	$623.44	$499.98	$608.48	$418.14	$508.88	$423.05	$514.85	$338.15	$411.53
50	$536.30	$656.97	$523.42	$641.19	$437.75	$536.24	$442.89	$542.54	$354.00	$433.65
51	$560.02	$686.02	$546.58	$669.56	$457.11	$559.96	$462.48	$566.54	$369.66	$452.83
52	$586.15	$718.03	$572.07	$700.79	$478.44	$586.09	$484.06	$592.97	$386.91	$473.96
53	$612.57	$750.40	$597.86	$732.38	$500.00	$612.50	$505.88	$619.70	$404.35	$495.33
54	$641.10	$785.35	$625.70	$766.48	$523.29	$641.03	$529.44	$648.56	$423.18	$518.40
55	$669.62	$820.28	$653.55	$800.60	$546.57	$669.55	$553.00	$677.43	$442.01	$541.46
56	$700.55	$858.17	$683.73	$837.57	$571.82	$700.48	$578.54	$708.71	$462.42	$566.46
57	$731.78	$896.43	$714.21	$874.91	$597.31	$731.70	$604.33	$740.30	$483.04	$591.72
58	$765.11	$937.26	$746.74	$914.76	$624.51	$765.02	$631.85	$774.02	$505.04	$618.67
59	$781.63	$957.50	$762.86	$934.50	$638.00	$781.55	$645.49	$790.73	$515.94	$632.03
60	$814.96	$998.33	$795.39	$974.35	$665.20	$814.87	$673.02	$824.45	$537.94	$658.98
61	$843.79	$1,033.64	$823.53	$1,008.82	$688.73	$843.69	$696.82	$853.60	$556.97	$682.29
62	$862.70	$1,056.81	$841.99	$1,031.44	$704.17	$862.61	$712.45	$872.75	$569.46	$697.59
63	$886.43	$1,085.88	$865.14	$1,059.80	$723.54	$886.34	$732.04	$896.75	$585.12	$716.77
64	$900.84	$1,103.53	$879.21	$1,077.03	$735.30	$900.74	$743.94	$911.33	$594.63	$728.42
65+	$900.84	$1,103.53	$879.21	$1,077.03	$735.30	$900.74	$743.94	$911.33	$594.63	$728.42

BASE RATES FOR YOUR COUNTY

You can find these plans on the Health Insurance Marketplace by using the Highmark Base Plan ID*.

	PLANS AVAILABLE IN ALLEGHENY, BEAVER, BUTLER, WASHINGTON & WESTMORELAND COUNTIES							
	Platinum		Gold		Silver		Catastrophic	
	Comprehensive Care Flex Blue PPO 500		Health Savings Blue PPO 1700		Health Savings Blue PPO Embedded 2700		Major Events Blue PPO 7150	
Base Plan ID*	70194PA0160003		70194PA0150005		70194PA0150003		33709PA0380004	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0 - 20	$378.76	$378.76	$314.81	$314.81	$259.38	$259.38	$126.61	$126.61
21	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
22	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
23	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
24	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
25	$598.86	$613.83	$497.75	$510.19	$410.11	$420.36	$200.19	$205.19
26	$610.79	$626.06	$507.67	$520.36	$418.28	$428.74	$204.18	$209.28
27	$625.10	$640.73	$519.57	$532.56	$428.09	$438.79	$208.96	$214.18
28	$648.36	$664.57	$538.90	$552.37	$444.02	$455.12	$216.74	$222.16
29	$667.45	$684.14	$554.77	$568.64	$457.09	$468.52	$223.12	$228.70
30	$676.99	$693.91	$562.70	$576.77	$463.62	$475.21	$226.31	$231.97
31	$691.31	$708.59	$574.60	$588.97	$473.43	$485.27	$231.09	$236.87
32	$705.62	$723.26	$586.50	$601.16	$483.23	$495.31	$235.88	$241.78
33	$714.57	$732.43	$593.93	$608.78	$489.36	$501.59	$238.87	$244.84
34	$724.11	$742.21	$601.86	$616.91	$495.89	$508.29	$242.06	$248.11
35	$728.89	$747.11	$605.83	$620.98	$499.16	$511.64	$243.65	$249.74
36	$733.66	$752.00	$609.80	$625.05	$502.43	$514.99	$245.25	$251.38
37	$738.43	$756.89	$613.76	$629.10	$505.70	$518.34	$246.84	$253.01
38	$743.20	$761.78	$617.73	$633.17	$508.97	$521.69	$248.44	$254.65
39	$752.75	$771.57	$625.66	$641.30	$515.50	$528.39	$251.63	$257.92
40	$762.29	$838.52	$633.59	$696.95	$522.04	$574.24	$254.82	$280.30
41	$776.60	$858.14	$645.49	$713.27	$531.84	$587.68	$259.61	$286.87
42	$790.32	$878.84	$656.90	$730.47	$541.24	$601.86	$264.19	$293.78
43	$809.41	$907.35	$672.76	$754.16	$554.31	$621.38	$270.57	$303.31
44	$833.27	$943.26	$692.59	$784.01	$570.65	$645.98	$278.55	$315.32
45	$861.30	$986.19	$715.89	$819.69	$589.85	$675.38	$287.92	$329.67
46	$894.71	$1,037.86	$743.66	$862.65	$612.72	$710.76	$299.09	$346.94
47	$932.28	$1,097.29	$774.89	$912.05	$638.45	$751.46	$311.65	$366.81
48	$975.23	$1,166.38	$810.58	$969.45	$667.86	$798.76	$326.00	$389.90
49	$1,017.58	$1,238.39	$845.78	$1,029.31	$696.87	$848.09	$340.16	$413.97
50	$1,065.30	$1,304.99	$885.45	$1,084.68	$729.55	$893.70	$356.11	$436.23
51	$1,112.42	$1,362.71	$924.61	$1,132.65	$761.82	$933.23	$371.86	$455.53
52	$1,164.31	$1,426.28	$967.74	$1,185.48	$797.35	$976.75	$389.21	$476.78
53	$1,216.80	$1,490.58	$1,011.37	$1,238.93	$833.30	$1,020.79	$406.76	$498.28
54	$1,273.46	$1,559.99	$1,058.47	$1,296.63	$872.10	$1,068.32	$425.70	$521.48
55	$1,330.13	$1,629.41	$1,105.57	$1,354.32	$910.91	$1,115.86	$444.64	$544.68
56	$1,391.56	$1,704.66	$1,156.63	$1,416.87	$952.98	$1,167.40	$465.18	$569.85
57	$1,453.60	$1,780.66	$1,208.19	$1,480.03	$995.47	$1,219.45	$485.91	$595.24
58	$1,519.81	$1,861.77	$1,263.22	$1,547.44	$1,040.81	$1,274.99	$508.05	$622.36
59	$1,552.61	$1,901.95	$1,290.49	$1,580.85	$1,063.27	$1,302.51	$519.01	$635.79
60	$1,618.82	$1,983.05	$1,345.52	$1,648.26	$1,108.61	$1,358.05	$541.14	$662.90
61	$1,676.08	$2,053.20	$1,393.11	$1,706.56	$1,147.83	$1,406.09	$560.29	$686.36
62	$1,713.66	$2,099.23	$1,424.35	$1,744.83	$1,173.56	$1,437.61	$572.85	$701.74
63	$1,760.78	$2,156.96	$1,463.51	$1,792.80	$1,205.83	$1,477.14	$588.60	$721.04
64	$1,789.41	$2,192.03	$1,487.31	$1,821.95	$1,225.44	$1,501.16	$598.17	$732.76
65+	$1,789.41	$2,192.03	$1,487.31	$1,821.95	$1,225.44	$1,501.16	$598.17	$732.76

BASE RATES FOR YOUR COUNTY

You can find these plans on the Health Insurance Marketplace by using the Highmark Base Plan ID*.

	PLANS AVAILABLE IN ERIE COUNTY									
	Gold		Gold		Silver		Silver		Bronze	
	my Connect Blue EPO 250G		my Connect Blue EPO 1000G		my Connect Blue EPO 1750S		my Connect Blue EPO 2500S		my Connect Blue EPO 6500B	
Base Plan ID*	33709PA0690003		33709PA0690005		33709PA0690001		33709PA0690002		33709PA0690004	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0 - 20	$190.68	$190.68	$186.10	$186.10	$155.64	$155.64	$157.47	$157.47	$125.86	$125.86
21	$300.28	$307.79	$293.07	$300.40	$245.10	$251.23	$247.98	$254.18	$198.21	$203.17
22	$300.28	$307.79	$293.07	$300.40	$245.10	$251.23	$247.98	$254.18	$198.21	$203.17
23	$300.28	$307.79	$293.07	$300.40	$245.10	$251.23	$247.98	$254.18	$198.21	$203.17
24	$300.28	$307.79	$293.07	$300.40	$245.10	$251.23	$247.98	$254.18	$198.21	$203.17
25	$301.48	$309.02	$294.24	$301.60	$246.08	$252.23	$248.97	$255.19	$199.00	$203.98
26	$307.49	$315.18	$300.10	$307.60	$250.98	$257.25	$253.93	$260.28	$202.97	$208.04
27	$314.69	$322.56	$307.14	$314.82	$256.86	$263.28	$259.88	$266.38	$207.72	$212.91
28	$326.40	$334.56	$318.57	$326.53	$266.42	$273.08	$269.55	$276.29	$215.45	$220.84
29	$336.01	$344.41	$327.95	$336.15	$274.27	$281.13	$277.49	$284.43	$221.80	$227.35
30	$340.82	$349.34	$332.63	$340.95	$278.19	$285.14	$281.46	$288.50	$224.97	$230.59
31	$348.02	$356.72	$339.67	$348.16	$284.07	$291.17	$287.41	$294.60	$229.73	$235.47
32	$355.23	$364.11	$346.70	$355.37	$289.95	$297.20	$293.36	$300.69	$234.48	$240.34
33	$359.74	$368.73	$351.10	$359.88	$293.63	$300.97	$297.08	$304.51	$237.46	$243.40
34	$364.54	$373.65	$355.79	$364.68	$297.55	$304.99	$301.05	$308.58	$240.63	$246.65
35	$366.94	$376.11	$358.13	$367.08	$299.51	$307.00	$303.03	$310.61	$242.21	$248.27
36	$369.34	$378.57	$360.48	$369.49	$301.47	$309.01	$305.02	$312.65	$243.80	$249.90
37	$371.75	$381.04	$362.82	$371.89	$303.43	$311.02	$307.00	$314.68	$245.38	$251.51
38	$374.15	$383.50	$365.17	$374.30	$305.39	$313.02	$308.98	$316.70	$246.97	$253.14
39	$378.95	$388.42	$369.85	$379.10	$309.32	$317.05	$312.95	$320.77	$250.14	$256.39
40	$383.76	$422.14	$374.54	$411.99	$313.24	$344.56	$316.92	$348.61	$253.31	$278.64
41	$390.96	$432.01	$381.58	$421.65	$319.12	$352.63	$322.87	$356.77	$258.07	$285.17
42	$397.87	$442.43	$388.32	$431.81	$324.76	$361.13	$328.57	$365.37	$262.63	$292.04
43	$407.48	$456.79	$397.70	$445.82	$332.60	$372.84	$336.51	$377.23	$268.97	$301.52
44	$419.49	$474.86	$409.42	$463.46	$342.40	$387.60	$346.43	$392.16	$276.90	$313.45
45	$433.60	$496.47	$423.19	$484.55	$353.92	$405.24	$358.08	$410.00	$286.22	$327.72
46	$450.42	$522.49	$439.61	$509.95	$367.65	$426.47	$371.97	$431.49	$297.32	$344.89
47	$469.34	$552.41	$458.07	$539.15	$383.09	$450.90	$387.59	$456.19	$309.80	$364.63
48	$490.96	$587.19	$479.17	$573.09	$400.74	$479.29	$405.45	$484.92	$324.07	$387.59
49	$512.28	$623.44	$499.98	$608.48	$418.14	$508.88	$423.05	$514.85	$338.15	$411.53
50	$536.30	$656.97	$523.42	$641.19	$437.75	$536.24	$442.89	$542.54	$354.00	$433.65
51	$560.02	$686.02	$546.58	$669.56	$457.11	$559.96	$462.48	$566.54	$369.66	$452.83
52	$586.15	$718.03	$572.07	$700.79	$478.44	$586.09	$484.06	$592.97	$386.91	$473.96
53	$612.57	$750.40	$597.86	$732.38	$500.00	$612.50	$505.88	$619.70	$404.35	$495.33
54	$641.10	$785.35	$625.70	$766.48	$523.29	$641.03	$529.44	$648.56	$423.18	$518.40
55	$669.62	$820.28	$653.55	$800.60	$546.57	$669.55	$553.00	$677.43	$442.01	$541.46
56	$700.55	$858.17	$683.73	$837.57	$571.82	$700.48	$578.54	$708.71	$462.42	$566.46
57	$731.78	$896.43	$714.21	$874.91	$597.31	$731.70	$604.33	$740.30	$483.04	$591.72
58	$765.11	$937.26	$746.74	$914.76	$624.51	$765.02	$631.85	$774.02	$505.04	$618.67
59	$781.63	$957.50	$762.86	$934.50	$638.00	$781.55	$645.49	$790.73	$515.94	$632.03
60	$814.96	$998.33	$795.39	$974.35	$665.20	$814.87	$673.02	$824.45	$537.94	$658.98
61	$843.79	$1,033.64	$823.53	$1,008.82	$688.73	$843.69	$696.82	$853.60	$556.97	$682.29
62	$862.70	$1,056.81	$841.99	$1,031.44	$704.17	$862.61	$712.45	$872.75	$569.46	$697.59
63	$886.43	$1,085.88	$865.14	$1,059.80	$723.54	$886.34	$732.04	$896.75	$585.12	$716.77
64	$900.84	$1,103.53	$879.21	$1,077.03	$735.30	$900.74	$743.94	$911.33	$594.63	$728.42
65+	$900.84	$1,103.53	$879.21	$1,077.03	$735.30	$900.74	$743.94	$911.33	$594.63	$728.42

BASE RATES FOR YOUR COUNTY

You can find these plans on the Health Insurance Marketplace by using the Highmark Base Plan ID*.

	PLANS AVAILABLE IN MCKEAN & VENANGO COUNTIES								PLANS AVAILABLE IN ERIE, MCKEAN & VENANGO COUNTIES							
	Gold		Silver		Silver		Bronze		Platinum		Gold		Silver		Catastrophic	
	my Community Blue Flex PPO 1700GQ		my Community Blue Flex PPO 2800SQE		my Community Blue Flex PPO 2100S		my Community Blue Flex PPO 6800B		Comprehensive Care Flex Blue PPO 500		Health Savings Blue PPO 1700		Health Savings Blue PPO Embedded 2700		Major Events Blue PPO 7150	
Base Plan ID*	33709PA0700005		33709PA0700006		33709PA0700007		33709PA0700008		70194PA0160003		70194PA0150005		70194PA0150003		33709PA0380004	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0 - 20	$212.10	$212.10	$176.65	$176.65	$171.24	$171.24	$136.04	$136.04	$378.76	$378.76	$314.81	$314.81	$259.38	$259.38	$126.61	$126.61
21	$334.02	$342.37	$278.19	$285.14	$269.67	$276.41	$214.23	$219.59	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
22	$334.02	$342.37	$278.19	$285.14	$269.67	$276.41	$214.23	$219.59	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
23	$334.02	$342.37	$278.19	$285.14	$269.67	$276.41	$214.23	$219.59	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
24	$334.02	$342.37	$278.19	$285.14	$269.67	$276.41	$214.23	$219.59	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
25	$335.36	$343.74	$279.30	$286.28	$270.75	$277.52	$215.09	$220.47	$598.86	$613.83	$497.75	$510.19	$410.11	$420.36	$200.19	$205.19
26	$342.04	$350.59	$284.87	$291.99	$276.14	$283.04	$219.37	$224.85	$610.79	$626.06	$507.67	$520.36	$418.28	$428.74	$204.18	$209.28
27	$350.05	$358.80	$291.54	$298.83	$282.61	$289.68	$224.51	$230.12	$625.10	$640.73	$519.57	$532.56	$428.09	$438.79	$208.96	$214.18
28	$363.08	$372.16	$302.39	$309.95	$293.13	$300.46	$232.87	$238.69	$648.36	$664.57	$538.90	$552.37	$444.02	$455.12	$216.74	$222.16
29	$373.77	$383.11	$311.29	$319.07	$301.76	$309.30	$239.72	$245.71	$667.45	$684.14	$554.77	$568.64	$457.09	$468.52	$223.12	$228.70
30	$379.11	$388.59	$315.75	$323.64	$306.08	$313.73	$243.15	$249.23	$676.99	$693.91	$562.70	$576.77	$463.62	$475.21	$226.31	$231.97
31	$387.13	$396.81	$322.42	$330.48	$312.55	$320.36	$248.29	$254.50	$691.31	$708.59	$574.60	$588.97	$473.43	$485.27	$231.09	$236.87
32	$395.15	$405.03	$329.10	$337.33	$319.02	$327.00	$253.43	$259.77	$705.62	$723.26	$586.50	$601.16	$483.23	$495.31	$235.88	$241.78
33	$400.16	$410.16	$333.27	$341.60	$323.06	$331.14	$256.65	$263.07	$714.57	$732.43	$593.93	$608.78	$489.36	$501.59	$238.87	$244.84
34	$405.50	$415.64	$337.72	$346.16	$327.38	$335.56	$260.08	$266.58	$724.11	$742.21	$601.86	$616.91	$495.89	$508.29	$242.06	$248.11
35	$408.17	$418.37	$339.95	$348.45	$329.54	$337.78	$261.79	$268.33	$728.89	$747.11	$605.83	$620.98	$499.16	$511.64	$243.65	$249.74
36	$410.84	$421.11	$342.17	$350.72	$331.69	$339.98	$263.50	$270.09	$733.66	$752.00	$609.80	$625.05	$502.43	$514.99	$245.25	$251.38
37	$413.52	$423.86	$344.40	$353.01	$333.85	$342.20	$265.22	$271.85	$738.43	$756.89	$613.76	$629.10	$505.70	$518.34	$246.84	$253.01
38	$416.19	$426.59	$346.62	$355.29	$336.01	$344.41	$266.93	$273.60	$743.20	$761.78	$617.73	$633.17	$508.97	$521.69	$248.44	$254.65
39	$421.53	$432.07	$351.08	$359.86	$340.32	$348.83	$270.36	$277.12	$752.75	$771.57	$625.66	$641.30	$515.50	$528.39	$251.63	$257.92
40	$426.88	$469.57	$355.53	$391.08	$344.64	$379.10	$273.79	$301.17	$762.29	$838.52	$633.59	$696.95	$522.04	$574.24	$254.82	$280.30
41	$434.89	$480.55	$362.20	$400.23	$351.11	$387.98	$278.93	$308.22	$776.60	$858.14	$645.49	$713.27	$531.84	$587.68	$259.61	$286.87
42	$442.58	$492.15	$368.60	$409.88	$357.31	$397.33	$283.85	$315.64	$790.32	$878.84	$656.90	$730.47	$541.24	$601.86	$264.19	$293.78
43	$453.27	$508.12	$377.50	$423.18	$365.94	$410.22	$290.71	$325.89	$809.41	$907.35	$672.76	$754.16	$554.31	$621.38	$270.57	$303.31
44	$466.63	$528.23	$388.63	$439.93	$376.73	$426.46	$299.28	$338.78	$833.27	$943.26	$692.59	$784.01	$570.65	$645.98	$278.55	$315.32
45	$482.32	$552.26	$401.71	$459.96	$389.40	$445.86	$309.35	$354.21	$861.30	$986.19	$715.89	$819.69	$589.85	$675.38	$287.92	$329.67
46	$501.03	$581.19	$417.29	$484.06	$404.51	$469.23	$321.35	$372.77	$894.71	$1,037.86	$743.66	$862.65	$612.72	$710.76	$299.09	$346.94
47	$522.07	$614.48	$434.81	$511.77	$421.49	$496.09	$334.84	$394.11	$932.28	$1,097.29	$774.89	$912.05	$638.45	$751.46	$311.65	$366.81
48	$546.12	$653.16	$454.84	$543.99	$440.91	$527.33	$350.27	$418.92	$975.23	$1,166.38	$810.58	$969.45	$667.86	$798.76	$326.00	$389.90
49	$569.84	$693.50	$474.59	$577.58	$460.06	$559.89	$365.48	$444.79	$1,017.58	$1,238.39	$845.78	$1,029.31	$696.87	$848.09	$340.16	$413.97
50	$596.56	$730.79	$496.85	$608.64	$481.63	$590.00	$382.61	$468.70	$1,065.30	$1,304.99	$885.45	$1,084.68	$729.55	$893.70	$356.11	$436.23
51	$622.95	$763.11	$518.82	$635.55	$502.93	$616.09	$399.54	$489.44	$1,112.42	$1,362.71	$924.61	$1,132.65	$761.82	$933.23	$371.86	$455.53
52	$652.01	$798.71	$543.03	$665.21	$526.40	$644.84	$418.18	$512.27	$1,164.31	$1,426.28	$967.74	$1,185.48	$797.35	$976.75	$389.21	$476.78
53	$681.40	$834.72	$567.51	$695.20	$550.13	$673.91	$437.03	$535.36	$1,216.80	$1,490.58	$1,011.37	$1,238.93	$833.30	$1,020.79	$406.76	$498.28
54	$713.13	$873.58	$593.94	$727.58	$575.75	$705.29	$457.38	$560.29	$1,273.46	$1,559.99	$1,058.47	$1,296.63	$872.10	$1,068.32	$425.70	$521.48
55	$744.86	$912.45	$620.36	$759.94	$601.36	$736.67	$477.73	$585.22	$1,330.13	$1,629.41	$1,105.57	$1,354.32	$910.91	$1,115.86	$444.64	$544.68
56	$779.27	$954.61	$649.02	$795.05	$629.14	$770.70	$499.80	$612.26	$1,391.56	$1,704.66	$1,156.63	$1,416.87	$952.98	$1,167.40	$465.18	$569.85
57	$814.01	$997.16	$677.95	$830.49	$657.19	$805.06	$522.08	$639.55	$1,453.60	$1,780.66	$1,208.19	$1,480.03	$995.47	$1,219.45	$485.91	$595.24
58	$851.08	$1,042.57	$708.83	$868.32	$687.12	$841.72	$545.86	$668.68	$1,519.81	$1,861.77	$1,263.22	$1,547.44	$1,040.81	$1,274.99	$508.05	$622.36
59	$869.45	$1,065.08	$724.13	$887.06	$701.95	$859.89	$557.64	$683.11	$1,552.61	$1,901.95	$1,290.49	$1,580.85	$1,063.27	$1,302.51	$519.01	$635.79
60	$906.53	$1,110.50	$755.01	$924.89	$731.88	$896.55	$581.42	$712.24	$1,618.82	$1,983.05	$1,345.52	$1,648.26	$1,108.61	$1,358.05	$541.14	$662.90
61	$938.60	$1,149.79	$781.71	$957.59	$757.77	$928.27	$601.99	$737.44	$1,676.08	$2,053.20	$1,393.11	$1,706.56	$1,147.83	$1,406.09	$560.29	$686.36
62	$959.64	$1,175.56	$799.24	$979.07	$774.76	$949.08	$615.48	$753.96	$1,713.66	$2,099.23	$1,424.35	$1,744.83	$1,173.56	$1,437.61	$572.85	$701.74
63	$986.03	$1,207.89	$821.22	$1,005.99	$796.07	$975.19	$632.41	$774.70	$1,760.78	$2,156.96	$1,463.51	$1,792.80	$1,205.83	$1,477.14	$588.60	$721.04
64	$1,002.06	$1,227.52	$834.57	$1,022.35	$809.01	$991.04	$642.69	$787.30	$1,789.41	$2,192.03	$1,487.31	$1,821.95	$1,225.44	$1,501.16	$598.17	$732.76
65+	$1,002.06	$1,227.52	$834.57	$1,022.35	$809.01	$991.04	$642.69	$787.30	$1,789.41	$2,192.03	$1,487.31	$1,821.95	$1,225.44	$1,501.16	$598.17	$732.76

BASE RATES FOR YOUR COUNTY

You can find these plans on the Health Insurance Marketplace by using the Highmark Base Plan ID*.

	PLANS AVAILABLE IN BEDFORD, BLAIR, CAMBRIA & SOMERSET COUNTIES															
	Gold		Silver		Silver		Bronze		Platinum		Gold		Silver		Catastrophic	
	my Community Blue Flex PPO 1700GQ		my Community Blue Flex PPO 2800SQE		my Community Blue Flex PPO 2100S		my Community Blue Flex PPO 6800B		Comprehensive Care Flex Blue PPO 500		Health Savings Blue PPO 1700		Health Savings Blue PPO Embedded 2700		Major Events Blue PPO 7150	
Base Plan ID*	33709PA0700005		33709PA0700006		33709PA0700007		33709PA0700008		70194PA0160003		70194PA0150005		70194PA0150003		33709PA0380004	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0 - 20	$212.10	$212.10	$176.65	$176.65	$171.24	$171.24	$136.04	$136.04	$378.76	$378.76	$314.81	$314.81	$259.38	$259.38	$126.61	$126.61
21	$334.02	$342.37	$278.19	$285.14	$269.67	$276.41	$214.23	$219.59	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
22	$334.02	$342.37	$278.19	$285.14	$269.67	$276.41	$214.23	$219.59	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
23	$334.02	$342.37	$278.19	$285.14	$269.67	$276.41	$214.23	$219.59	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
24	$334.02	$342.37	$278.19	$285.14	$269.67	$276.41	$214.23	$219.59	$596.47	$611.38	$495.77	$508.16	$408.48	$418.69	$199.39	$204.37
25	$335.36	$343.74	$279.30	$286.28	$270.75	$277.52	$215.09	$220.47	$598.86	$613.83	$497.75	$510.19	$410.11	$420.36	$200.19	$205.19
26	$342.04	$350.59	$284.87	$291.99	$276.14	$283.04	$219.37	$224.85	$610.79	$626.06	$507.67	$520.36	$418.28	$428.74	$204.18	$209.28
27	$350.05	$358.80	$291.54	$298.83	$282.61	$289.68	$224.51	$230.12	$625.10	$640.73	$519.57	$532.56	$428.09	$438.79	$208.96	$214.18
28	$363.08	$372.16	$302.39	$309.95	$293.13	$300.46	$232.87	$238.69	$648.36	$664.57	$538.90	$552.37	$444.02	$455.12	$216.74	$222.16
29	$373.77	$383.11	$311.29	$319.07	$301.76	$309.30	$239.72	$245.71	$667.45	$684.14	$554.77	$568.64	$457.09	$468.52	$223.12	$228.70
30	$379.11	$388.59	$315.75	$323.64	$306.08	$313.73	$243.15	$249.23	$676.99	$693.91	$562.70	$576.77	$463.62	$475.21	$226.31	$231.97
31	$387.13	$396.81	$322.42	$330.48	$312.55	$320.36	$248.29	$254.50	$691.31	$708.59	$574.60	$588.97	$473.43	$485.27	$231.09	$236.87
32	$395.15	$405.03	$329.10	$337.33	$319.02	$327.00	$253.43	$259.77	$705.62	$723.26	$586.50	$601.16	$483.23	$495.31	$235.88	$241.78
33	$400.16	$410.16	$333.27	$341.60	$323.06	$331.14	$256.65	$263.07	$714.57	$732.43	$593.93	$608.78	$489.36	$501.59	$238.87	$244.84
34	$405.50	$415.64	$337.72	$346.16	$327.38	$335.56	$260.08	$266.58	$724.11	$742.21	$601.86	$616.91	$495.89	$508.29	$242.06	$248.11
35	$408.17	$418.37	$339.95	$348.45	$329.54	$337.78	$261.79	$268.33	$728.89	$747.11	$605.83	$620.98	$499.16	$511.64	$243.65	$249.74
36	$410.84	$421.11	$342.17	$350.72	$331.69	$339.98	$263.50	$270.09	$733.66	$752.00	$609.80	$625.05	$502.43	$514.99	$245.25	$251.38
37	$413.52	$423.86	$344.40	$353.01	$333.85	$342.20	$265.22	$271.85	$738.43	$756.89	$613.76	$629.10	$505.70	$518.34	$246.84	$253.01
38	$416.19	$426.59	$346.62	$355.29	$336.01	$344.41	$266.93	$273.60	$743.20	$761.78	$617.73	$633.17	$508.97	$521.69	$248.44	$254.65
39	$421.53	$432.07	$351.08	$359.86	$340.32	$348.83	$270.36	$277.12	$752.75	$771.57	$625.66	$641.30	$515.50	$528.39	$251.63	$257.92
40	$426.88	$469.57	$355.53	$391.08	$344.64	$379.10	$273.79	$301.17	$762.29	$838.52	$633.59	$696.95	$522.04	$574.24	$254.82	$280.30
41	$434.89	$480.55	$362.20	$400.23	$351.11	$387.98	$278.93	$308.22	$776.60	$858.14	$645.49	$713.27	$531.84	$587.68	$259.61	$286.87
42	$442.58	$492.15	$368.60	$409.88	$357.31	$397.33	$283.85	$315.64	$790.32	$878.84	$656.90	$730.47	$541.24	$601.86	$264.19	$293.78
43	$453.27	$508.12	$377.50	$423.18	$365.94	$410.22	$290.71	$325.89	$809.41	$907.35	$672.76	$754.16	$554.31	$621.38	$270.57	$303.31
44	$466.63	$528.23	$388.63	$439.93	$376.73	$426.46	$299.28	$338.78	$833.27	$943.26	$692.59	$784.01	$570.65	$645.98	$278.55	$315.32
45	$482.32	$552.26	$401.71	$459.96	$389.40	$445.86	$309.35	$354.21	$861.30	$986.19	$715.89	$819.69	$589.85	$675.38	$287.92	$329.67
46	$501.03	$581.19	$417.29	$484.06	$404.51	$469.23	$321.35	$372.77	$894.71	$1,037.86	$743.66	$862.65	$612.72	$710.76	$299.09	$346.94
47	$522.07	$614.48	$434.81	$511.77	$421.49	$496.09	$334.84	$394.11	$932.28	$1,097.29	$774.89	$912.05	$638.45	$751.46	$311.65	$366.81
48	$546.12	$653.16	$454.84	$543.99	$440.91	$527.33	$350.27	$418.92	$975.23	$1,166.38	$810.58	$969.45	$667.86	$798.76	$326.00	$389.90
49	$569.84	$693.50	$474.59	$577.58	$460.06	$559.89	$365.48	$444.79	$1,017.58	$1,238.39	$845.78	$1,029.31	$696.87	$848.09	$340.16	$413.97
50	$596.56	$730.79	$496.85	$608.64	$481.63	$590.00	$382.61	$468.70	$1,065.30	$1,304.99	$885.45	$1,084.68	$729.55	$893.70	$356.11	$436.23
51	$622.95	$763.11	$518.82	$635.55	$502.93	$616.09	$399.54	$489.44	$1,112.42	$1,362.71	$924.61	$1,132.65	$761.82	$933.23	$371.86	$455.53
52	$652.01	$798.71	$543.03	$665.21	$526.40	$644.84	$418.18	$512.27	$1,164.31	$1,426.28	$967.74	$1,185.48	$797.35	$976.75	$389.21	$476.78
53	$681.40	$834.72	$567.51	$695.20	$550.13	$673.91	$437.03	$535.36	$1,216.80	$1,490.58	$1,011.37	$1,238.93	$833.30	$1,020.79	$406.76	$498.28
54	$713.13	$873.58	$593.94	$727.58	$575.75	$705.29	$457.38	$560.29	$1,273.46	$1,559.99	$1,058.47	$1,296.63	$872.10	$1,068.32	$425.70	$521.48
55	$744.86	$912.45	$620.36	$759.94	$601.36	$736.67	$477.73	$585.22	$1,330.13	$1,629.41	$1,105.57	$1,354.32	$910.91	$1,115.86	$444.64	$544.68
56	$779.27	$954.61	$649.02	$795.05	$629.14	$770.70	$499.80	$612.26	$1,391.56	$1,704.66	$1,156.63	$1,416.87	$952.98	$1,167.40	$465.18	$569.85
57	$814.01	$997.16	$677.95	$830.49	$657.19	$805.06	$522.08	$639.55	$1,453.60	$1,780.66	$1,208.19	$1,480.03	$995.47	$1,219.45	$485.91	$595.24
58	$851.08	$1,042.57	$708.83	$868.32	$687.12	$841.72	$545.86	$668.68	$1,519.81	$1,861.77	$1,263.22	$1,547.44	$1,040.81	$1,274.99	$508.05	$622.36
59	$869.45	$1,065.08	$724.13	$887.06	$701.95	$859.89	$557.64	$683.11	$1,552.61	$1,901.95	$1,290.49	$1,580.85	$1,063.27	$1,302.51	$519.01	$635.79
60	$906.53	$1,110.50	$755.01	$924.89	$731.88	$896.55	$581.42	$712.24	$1,618.82	$1,983.05	$1,345.52	$1,648.26	$1,108.61	$1,358.05	$541.14	$662.90
61	$938.60	$1,149.79	$781.71	$957.59	$757.77	$928.27	$601.99	$737.44	$1,676.08	$2,053.20	$1,393.11	$1,706.56	$1,147.83	$1,406.09	$560.29	$686.36
62	$959.64	$1,175.56	$799.24	$979.07	$774.76	$949.08	$615.48	$753.96	$1,713.66	$2,099.23	$1,424.35	$1,744.83	$1,173.56	$1,437.61	$572.85	$701.74
63	$986.03	$1,207.89	$821.22	$1,005.99	$796.07	$975.19	$632.41	$774.70	$1,760.78	$2,156.96	$1,463.51	$1,792.80	$1,205.83	$1,477.14	$588.60	$721.04
64	$1,002.06	$1,227.52	$834.57	$1,022.35	$809.01	$991.04	$642.69	$787.30	$1,789.41	$2,192.03	$1,487.31	$1,821.95	$1,225.44	$1,501.16	$598.17	$732.76
65+	$1,002.06	$1,227.52	$834.57	$1,022.35	$809.01	$991.04	$642.69	$787.30	$1,789.41	$2,192.03	$1,487.31	$1,821.95	$1,225.44	$1,501.16	$598.17	$732.76

BASE RATES FOR YOUR COUNTY

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

	PLANS AVAILABLE IN ALLEGHENY, ARMSTRONG, BEAVER, BEDFORD, BLAIR, BUTLER, CAMBRIA, CAMERON, CLARION, CLEARFIELD, CRAWFORD, ELK, ERIE, FAYETTE, FOREST, GREENE, HUNTINGDON, INDIANA, JEFFERSON, LAWRENCE, MCKEAN, MERCER, POTTER, SOMERSET, VENANGO, WARREN, WASHINGTON & WESTMORELAND COUNTIES				PLAN AVAILABLE IN ARMSTRONG, CAMERON, CLARION, CLEARFIELD, CRAWFORD, ELK, FAYETTE, FOREST, GREENE, HUNTINGDON, INDIANA, JEFFERSON, LAWRENCE, MERCER, POTTER & WARREN COUNTIES		PLANS AVAILABLE IN CENTRE* COUNTY *NOTE: YOU MUST RESIDE IN ONE OF THE FOLLOWING ZIP CODES IN CENTRE COUNTY TO ENROLL IN ONE OF THESE PLANS – 16677, 16686, 16829, 16845, 16859, 16865, 16866, 16874, 16877.					
	Bronze		Gold		Catastrophic		Bronze		Gold		Catastrophic	
	Shared Cost Blue PPO 6800		Care Guide Blue HMO 750		Major Events Blue PPO 7150		Shared Cost Blue PPO 6800		Care Guide Blue HMO 750		Major Events Blue PPO 7150	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0 - 20	$207.07	$207.07	$296.28	$296.28	$126.61	$126.61	$222.01	$222.01	$317.66	$317.66	$135.75	$135.75
21	$326.09	$334.24	$466.58	$478.24	$199.39	$204.37	$349.62	$358.36	$500.25	$512.76	$213.78	$219.12
22	$326.09	$334.24	$466.58	$478.24	$199.39	$204.37	$349.62	$358.36	$500.25	$512.76	$213.78	$219.12
23	$326.09	$334.24	$466.58	$478.24	$199.39	$204.37	$349.62	$358.36	$500.25	$512.76	$213.78	$219.12
24	$326.09	$334.24	$466.58	$478.24	$199.39	$204.37	$349.62	$358.36	$500.25	$512.76	$213.78	$219.12
25	$327.39	$335.57	$468.45	$480.16	$200.19	$205.19	$351.02	$359.80	$502.25	$514.81	$214.64	$220.01
26	$333.92	$342.27	$477.78	$489.72	$204.18	$209.28	$358.01	$366.96	$512.26	$525.07	$218.91	$224.38
27	$341.74	$350.28	$488.98	$501.20	$208.96	$214.18	$366.40	$375.56	$524.26	$537.37	$224.04	$229.64
28	$354.46	$363.32	$507.17	$519.85	$216.74	$222.16	$380.04	$389.54	$543.77	$557.36	$232.38	$238.19
29	$364.89	$374.01	$522.10	$535.15	$223.12	$228.70	$391.22	$401.00	$559.78	$573.77	$239.22	$245.20
30	$370.11	$379.36	$529.57	$542.81	$226.31	$231.97	$396.82	$406.74	$567.78	$581.97	$242.64	$248.71
31	$377.94	$387.39	$540.77	$554.29	$231.09	$236.87	$405.21	$415.34	$579.79	$594.28	$247.77	$253.96
32	$385.76	$395.40	$551.96	$565.76	$235.88	$241.78	$413.60	$423.94	$591.80	$606.60	$252.90	$259.22
33	$390.66	$400.43	$558.96	$572.93	$238.87	$244.84	$418.84	$429.31	$599.30	$614.28	$256.11	$262.51
34	$395.87	$405.77	$566.43	$580.59	$242.06	$248.11	$424.44	$435.05	$607.30	$622.48	$259.53	$266.02
35	$398.48	$408.44	$570.16	$584.41	$243.65	$249.74	$427.24	$437.92	$611.31	$626.59	$261.24	$267.77
36	$401.09	$411.12	$573.89	$588.24	$245.25	$251.38	$430.03	$440.78	$615.31	$630.69	$262.95	$269.52
37	$403.70	$413.79	$577.63	$592.07	$246.84	$253.01	$432.83	$443.65	$619.31	$634.79	$264.66	$271.28
38	$406.31	$416.47	$581.36	$595.89	$248.44	$254.65	$435.63	$446.52	$623.31	$638.89	$266.37	$273.03
39	$411.53	$421.82	$588.82	$603.54	$251.63	$257.92	$441.22	$452.25	$631.32	$647.10	$269.79	$276.53
40	$416.74	$458.41	$596.29	$655.92	$254.82	$280.30	$446.81	$491.49	$639.32	$703.25	$273.21	$300.53
41	$424.57	$469.15	$607.49	$671.28	$259.61	$286.87	$455.21	$503.01	$651.33	$719.72	$278.34	$307.57
42	$432.07	$480.46	$618.22	$687.46	$264.19	$293.78	$463.25	$515.13	$662.83	$737.07	$283.26	$314.99
43	$442.50	$496.04	$633.15	$709.76	$270.57	$303.31	$474.43	$531.84	$678.84	$760.98	$290.10	$325.20
44	$455.55	$515.68	$651.81	$737.85	$278.55	$315.32	$488.42	$552.89	$698.85	$791.10	$298.65	$338.07
45	$470.87	$539.15	$673.74	$771.43	$287.92	$329.67	$504.85	$578.05	$722.36	$827.10	$308.70	$353.46
46	$489.14	$567.40	$699.87	$811.85	$299.09	$346.94	$524.43	$608.34	$750.38	$870.44	$320.67	$371.98
47	$509.68	$599.89	$729.26	$858.34	$311.65	$366.81	$546.46	$643.18	$781.89	$920.28	$334.14	$393.28
48	$533.16	$637.66	$762.86	$912.38	$326.00	$389.90	$571.63	$683.67	$817.91	$978.22	$349.53	$418.04
49	$556.31	$677.03	$795.99	$968.72	$340.16	$413.97	$596.45	$725.88	$853.43	$1,038.62	$364.71	$443.85
50	$582.40	$713.44	$833.31	$1,020.80	$356.11	$436.23	$624.42	$764.91	$893.45	$1,094.48	$381.81	$467.72
51	$608.16	$745.00	$870.17	$1,065.96	$371.86	$455.53	$652.04	$798.75	$932.97	$1,142.89	$398.70	$488.41
52	$636.53	$779.75	$910.76	$1,115.68	$389.21	$476.78	$682.46	$836.01	$976.49	$1,196.20	$417.30	$511.19
53	$665.22	$814.89	$951.82	$1,165.98	$406.76	$498.28	$713.22	$873.69	$1,020.51	$1,250.12	$436.11	$534.23
54	$696.20	$852.85	$996.15	$1,220.28	$425.70	$521.48	$746.44	$914.39	$1,068.03	$1,308.34	$456.42	$559.11
55	$727.18	$890.80	$1,040.47	$1,274.58	$444.64	$544.68	$779.65	$955.07	$1,115.56	$1,366.56	$476.73	$583.99
56	$760.77	$931.94	$1,088.53	$1,333.45	$465.18	$569.85	$815.66	$999.18	$1,167.08	$1,429.67	$498.75	$610.97
57	$794.68	$973.48	$1,137.06	$1,392.90	$485.91	$595.24	$852.02	$1,043.72	$1,219.11	$1,493.41	$520.98	$638.20
58	$830.88	$1,017.83	$1,188.85	$1,456.34	$508.05	$622.36	$890.83	$1,091.27	$1,274.64	$1,561.43	$544.71	$667.27
59	$848.81	$1,039.79	$1,214.51	$1,487.77	$519.01	$635.79	$910.06	$1,114.82	$1,302.15	$1,595.13	$556.47	$681.68
60	$885.01	$1,084.14	$1,266.30	$1,551.22	$541.14	$662.90	$948.87	$1,162.37	$1,357.68	$1,663.16	$580.20	$710.75
61	$916.31	$1,122.48	$1,311.09	$1,606.09	$560.29	$686.36	$982.43	$1,203.48	$1,405.70	$1,721.98	$600.72	$735.88
62	$936.86	$1,147.65	$1,340.48	$1,642.09	$572.85	$701.74	$1,004.46	$1,230.46	$1,437.22	$1,760.59	$614.19	$752.38
63	$962.62	$1,179.21	$1,377.34	$1,687.24	$588.60	$721.04	$1,032.08	$1,264.30	$1,476.74	$1,809.01	$631.08	$773.07
64	$978.27	$1,198.38	$1,399.74	$1,714.68	$598.17	$732.76	$1,048.86	$1,284.85	$1,500.75	$1,838.42	$641.34	$785.64
65+	$978.27	$1,198.38	$1,399.74	$1,714.68	$598.17	$732.76	$1,048.86	$1,284.85	$1,500.75	$1,838.42	$641.34	$785.64

We're Here to Help

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

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

- Call us at **1-855-329-0690** (TTY/TDD 711)
- Visit your Highmark health insurance store
- Visit **DiscoverHighmark.com**
- Talk to your local insurance agent

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

HIGHMARK.

BLOG

Visit us on Social Media.

27283 9/16 CS207384