Your smile matters and so does your vision.

Our ACA plans that include dental and vision have the same benefits, regardless of metal level.

Dental

- $50 individual deductible; $150 family deductible / $1,250 annual maximum per person.
- 100% coverage on cleanings (two per year), X-rays, and sealants.
- 80% coverage on minor restorative services like fillings and repairs of existing crowns.
- 50% coverage on major restorative services like root canals and new crowns.

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

Vision

- Free annual eye exam.
- Allowance for frames or contacts.
  - Frame allowance up to $150, plus 20% discount on any overages.*
  - Contact allowance up to $150, plus 15% discount on any overages.*

Our plans use the Davis Vision network. To see a list of in-network providers, visit **highmark.com** and select **Doctors and Drugs** under **Plans**.

*** Allowance is for either frames or contacts.**

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

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

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

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

Basic Diagnostic Services include Diagnostic X-ray, diagnostic medical and allergy testing. Basic diagnostic services require one copay (or, for some plans, coinsurance after deductible) per date of service and type of service.

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.

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

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

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

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

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.

You can find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers on our website. Visit highmark.com and enter your ZIP code. Select Plans followed by Shop Individual and Family Plans. Scroll to the blue bar at bottom of the page. Look for Be Informed and select Quality Assurance.

You should confirm the network status of a provider prior to receiving services. You can call My Care Navigator at 1-888-BLUE-428 to confirm if a doctor or facility will be in network in 2023.

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield or Highmark Coverage Advantage, both of which are independent licensees of the Blue Cross Blue Shield Association.

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

Discrimination is Against the Law

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

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

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

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

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.

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

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

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 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 se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

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

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

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

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

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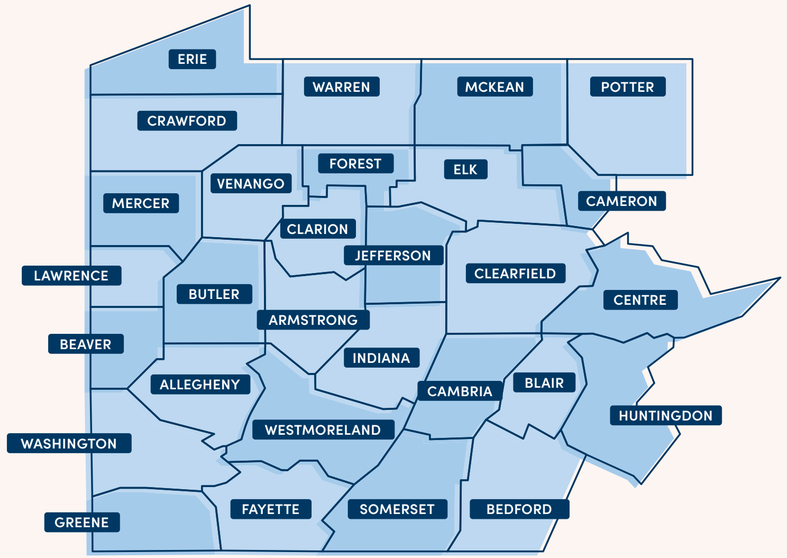
Let's look at your options for a 2023 plan.

Together Blue EPO • my Direct Blue EPO • my Blue Access PPO



HIGHMARK.
Because Life.™

Individual and Family Plan Guide

BENEFIT	Bronze		
	Bronze 8900	**Bronze 6900 HSA — Custom Drug Benefit**	**Bronze 3800**
Plan Availability	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO
In-Network Deductible	Individual: $8,900 Family: $17,800	Individual: $6,900 Family: $13,800	Individual: $3,800 Family: $7,600
In-Network, Out-of-Pocket Maximum	Individual: $8,900 Family: $17,800	Individual: $6,900 Family: $13,800	Individual: $9,100 Family: $18,200
Primary Care Visit	$0 after deductible	$0 after deductible	$65 copay
Specialist Visit	$0 after deductible	$0 after deductible	$65 copay
Outpatient Mental Health and Substance Abuse Visits	$0 after deductible	$0 after deductible	$65 copay
Speech, Physical, and Occupational Therapy and Chiropractic Care[1]	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test (Lab/X-ray)	$0 after deductible	$0 after deductible	Lab: $65 copay X-ray: $150 copay
Urgent Care[2]	$0 after deductible	$0 after deductible	$100 copay
Emergency Services	$0 after deductible	$0 after deductible	50% after deductible
Hospital Inpatient (including Maternity)[3]	$0 after deductible	$0 after deductible	50% after deductible
Pharmacy Summary[4]	$0/$0/$0/$0 after deductible	$0/$0/$0/$0 after deductible	50%/50%/50%/50% after deductible
Includes Dental and Vision Option	No	No	Yes

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

PPO plans contain out-of-network benefits.

This is not a comprehensive listing of all our available products. Please refer to the 2023 Product Brochure for a complete list.

BENEFIT	Extra Savings Silver			
	Silver 0	**Premier Silver 0**	**Silver 0**	**Premier Silver 0**
	138-149% FPL		150-199% FPL	
Plan Availability	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO
In-Network Deductible	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network, Out-of-Pocket Maximum	Individual: $1,200 Family: $2,400	Individual: $1,200 Family: $2,400	Individual: $2,800 Family: $5,600	Individual: $3,000 Family: $6,000
Primary Care Visit	$1 copay	$0 copay	$15 copay	$0 copay
Specialist Visit	$1 copay	$0 copay	$15 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$1 copay	$0 copay	$15 copay	$0 copay
Speech, Physical, and Occupational Therapy and Chiropractic Care[1]	$5 copay	$0 copay	$30 copay	$0 copay
Diagnostic Test (Lab/X-ray)	$5 copay	$0 copay	$25 copay	$25 copay
Urgent Care[2]	$5 copay	$5 copay	$30 copay	$10 copay
Emergency Services	$75 copay	$75 copay	$275 copay	$300 copay
Hospital Inpatient (including Maternity)[3]	$100 copay	$100 copay	$375 copay	$375 copay
Pharmacy Summary[4]	$0/$5/$15/50%	$0/$5/$15/50%	$0/$10/$50/50%	$0/$10/$50/50%
Includes Dental and Vision Option	No	Yes	No	Yes

Income guidelines:
Household size of 1: 138 – 149% FPL: $18,755 – $20,384; 150 – 199% FPL: $20,385 – $27,179
Household size of 2: 138 – 149% FPL: $25,269 – $27,464; 150 – 199% FPL: $27,465 – $36,619
Household size of 3: 138 – 149% FPL: $31,782 – $34,544; 150 – 199% FPL: $34,545 – $46,059
Household size of 4: 138 – 149% FPL: $38,296 – $41,624; 150 – 199% FPL: $41,625 – $55,499

BENEFIT	Gold			
	Gold 1700 HSA[5]	**Gold 0**	**Premier Gold 0**	**Together Blue Diabetes**
Plan Availability	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO
In-Network Deductible	Individual: $1,700 Family: $3,400	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network, Out-of-Pocket Maximum	Individual: $5,700 Family: $11,400	Individual: $7,500 Family: $15,000	Individual: $6,500 Family: $13,000	Individual: $7,500 Family: $15,000
Primary Care Visit	$20 after deductible	$20 copay	$15 copay	$20 copay
Specialist Visit	$20 after deductible	$20 copay	$15 copay	$20 copay $5 Select Specialist[5]
Outpatient Mental Health and Substance Abuse Visits	$20 after deductible	$20 copay	$15 copay	$20 copay
Speech, Physical, and Occupational Therapy and Chiropractic Care[1]	$20 after deductible	$45 copay	$40 copay	$45 copay
Diagnostic Test (Lab/X-ray)	$20 after deductible	$35 copay	$30 copay	$35 copay $0 Select Labs[5]
Urgent Care[2]	$40 after deductible	$40 copay	$30 copay	$40 copay
Emergency Services	$175 after deductible	$300 copay	$250 copay	$300 copay
Hospital Inpatient (including Maternity)[3]	$300 after deductible	$500 copay	$375 copay	$500 copay
Pharmacy Summary[4]	$0/$30/$150/50% after deductible	$0/$30/$150/50%	$0/$25/$75/50%	$0/$30/$150/50% $3 Select Rx[6]
Includes Dental and Vision Option	No	Yes	Yes	Yes

[1] Limit of 30 combined physical and occupational therapy visits per benefit period. Limit does not apply to therapy services for the treatment of Mental Health or Substance Abuse.

[2] The copayment, if any, does not apply to urgent care services prescribed for the treatment of Mental Health or Substance Abuse.

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

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

[5] This plan has a Non-Embedded deductible. See 2023 product brochures disclosures disclosures for more information.

[6] Unique benefits to Together Blue Diabetes. See 2023 product brochure for more information.