



# Zero reasons your health can't be a priority.

Individual and family plan offerings

For benefit period:  
January 1 to December 31, 2024



Because Life.™



# Say hello to a great health plan.

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

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

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# Why choose a Highmark health plan?

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



1

## Expert care, close to home.

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

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2

## Coverage that travels with you.

Planning to hit the road or travel abroad this year? With **BlueCard®**, your health care benefits go with you — across the country and around the world. We give you access to doctors and hospitals almost everywhere for urgent and emergency health care needs, so you'll have peace of mind when you're on the go.

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3

## No red tape.

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

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4

## All your care, all in one plan.

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

**Our plans with “Adult Dental and Vision” in their name include these benefits, so there’s no need to purchase separate plans.**

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5

## Easy access to top-performing specialists.

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

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6

## Mental health care that’s exactly the right fit.

Our Mental Well-Being solution provides expanded, quicker access to mental health care. A personalized care plan will help guide you to the right resources based on your needs.

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**And that’s just for starters.**

Turn the page for even more reasons to choose Highmark.

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





#### VIRTUAL HEALTH

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

Get a diagnosis, treatment plan, or prescription any time, right from your phone or computer. Best of all, virtual health services are available through many in-network providers. That's laid-back-in-a-recliner easy.

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#### BLUES ON CALL<sup>SM</sup>

## Answers from a health pro, 24/7.

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

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#### THE HIGHMARK MEMBER APP AND WEBSITE

## Your entire plan at your fingertips.

No more searching for old files or waiting on snail mail. Your digital ID card, Find a Doctor tool, deductible progress, and claims status are all available on the My Highmark app or at [myhighmark.com](https://myhighmark.com).

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#### VIRTUAL PHYSICAL CARE

## Physical care from the comfort of home.

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

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#### MY CARE NAVIGATOR<sup>SM</sup>

## Your appointments, booked for you.

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

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#### HEALTH SAVINGS ACCOUNT

## Helping you save for today and tomorrow.

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

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# **Need help with your health goals?**

**We've got you covered.**



**\$250 WELLNESS CARD**

## Redeemable for gym memberships.

Consider it a little something extra for the journey to good health.\*

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**WELLNESS**

## Personalized support for health goals.

Looking to lose weight? Quit smoking? Be more active? Get guidance based on your lifestyle, wellness tools, and access to experienced wellness coaches to make healthy choices and keep you motivated. Once you're enrolled, visit [myhighmark.com](https://myhighmark.com).

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**BLUE365®**

## Discounts to help you stay healthy and active.

With Blue365, you get exclusive discounts on personal wellness items and services. Check out member-only deals at [blue365deals.com/bcbswny](https://blue365deals.com/bcbswny).

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**Let's take a minute  
to cover the basics  
of ACA plans.**

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# Here's your ACA Enrollment Checklist.

You'll need this info for each person who will be covered on your plan.

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

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

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# Enrollment dates

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

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## 1 Open Enrollment Period

### November 16, 2023 – January 31, 2024

If you sign up by December 15, 2023, your plan takes effect on January 1, 2024.

If you sign up between December 16, 2023, and January 15, 2024, your plan takes effect on February 1, 2024.

If you sign up between January 16, 2024, and January 31, 2024, your plan takes effect on March 1, 2024.

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## 2 Special Enrollment Period

### Can happen any time throughout the year

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

If you think you're eligible for a Special Enrollment Period, you may be asked to submit documents to verify it. You can go to [highmark.com](https://www.highmark.com) for more information.



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# Metal levels

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

## Bronze



**60%**  
of costs covered  
by your plan

**40%**  
out-of-pocket  
costs

If you don't use a lot of health care services and/or want to keep premium payments low, a Bronze plan might be for you.

## Silver



**70%**  
of costs covered  
by your plan

**30%**  
out-of-pocket  
costs

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

## Gold



**80%**  
of costs covered  
by your plan

**20%**  
out-of-pocket  
costs

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

## Platinum



**90%**  
of costs covered  
by your plan

**10%**  
out-of-pocket  
costs

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

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

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# Ways to save

## Advance premium tax credits (APTC)

APTCs may be applied — in advance — to lower what you pay each month for your premium on any level [nystateofhealth.ny.gov](https://nystateofhealth.ny.gov) plan except Catastrophic.

## Extra ACA assistance

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

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

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### Dean and Vanessa

Married couple,  
64 years old, non-smokers  
Annual income: \$78,930

**Before:** \$2,741 monthly premium

**After:** \$559 monthly premium

**Savings: \$26,184/year**

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Premiums and advance premium tax credits (APTC) will vary by county. The APTC can lower the monthly premium. Examples are based on the second-lowest cost Silver plan available on [nystateofhealth.ny.gov](https://nystateofhealth.ny.gov) in a given area. The price of this plan is used to calculate premium subsidies.

Financial help in the form of advance premium tax credits (APTCs) or cost-sharing reductions (CSRs) are available only on plans purchased through [nystateofhealth.ny.gov](https://nystateofhealth.ny.gov).

# Financial help

To see if you're eligible for financial help, locate your qualifying income and household size on the chart below. If you believe you will qualify for Medicaid or the Essential Plan, contact [nystateofhealth.ny.gov](https://nystateofhealth.ny.gov) or call **855-355-5777**. Otherwise, refer to the Base plans for your county to find the plan that meets your needs.

Even if you don't qualify for the Essential Plan, you may be eligible for advance premium tax credits.

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

Who needs coverage?	Eligible for Medicaid	Eligible for Essential plans		Eligible for CSRs and APTCs		Eligible for APTCs
	100% - 138%	138%	200%	200%	250%	250% or more
Single	Less than \$20,120	\$20,121	\$29,160	\$29,160	\$36,450	\$36,450 or more
Family of 2	Less than \$27,214	\$27,215	\$39,440	\$39,440	\$49,300	\$49,300 or more
Family of 3	Less than \$34,307	\$34,308	\$49,720	\$49,720	\$62,150	\$62,150 or more
Family of 4	Less than \$41,400	\$41,401	\$60,000	\$60,000	\$75,000	\$75,000 or more
Family of 5	Less than \$48,493	\$48,494	\$70,280	\$70,280	\$87,850	\$87,850 or more
Family of 6	Less than \$55,586	\$55,587	\$80,560	\$80,560	\$100,700	\$100,700 or more
Family of 7	Less than \$62,680	\$62,681	\$90,840	\$90,840	\$113,550	\$113,550 or more
Family of 8	Less than \$69,773	\$69,774	\$101,120	\$101,120	\$126,400	\$126,400 or more

Essential plan eligibility subject to final approval by CMS. New Yorkers not eligible for the Essential Plan, but with incomes in the range might be eligible for plans with cost-sharing reductions at alternative dollar thresholds.

Essential plan enrollment is limited to those aged 19-64. To confirm your eligibility for one of five levels of Essential plans, contact New York State of Health by calling **855-355-5777** or visiting [nystateofhealth.ny.gov](https://nystateofhealth.ny.gov).

Most individuals and families with household incomes 100% or more of the federal poverty limit (FPL) will qualify for premium tax credits. These credits help lower the cost of health insurance coverage and are based on the second-lowest-cost Silver plan available in your area on New York state marketplace. The second-lowest-cost Silver plan is also known as the "benchmark plan." Those households with annual incomes 400% or more of the FPL will pay no more than 8.5% of their household income on health insurance premiums for the benchmark plan.\*

This chart is only applicable for coverage in 2024 and in the 48 contiguous states and the District of Columbia. For families/households with more than 8 persons, add \$5,140 for each additional person.

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

\*HHS Poverty Guidelines for 2023 (March 14, 2023). Retrieved from <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>.

**Check to see if you qualify for financial help.**  
**Call 855-355-5777.**

# 2024 Highmark products and plan designs

Phew, that was a lot of good info. Now, let's take a look at the products and plans available in your area for 2024.

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# You get all the essentials.

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

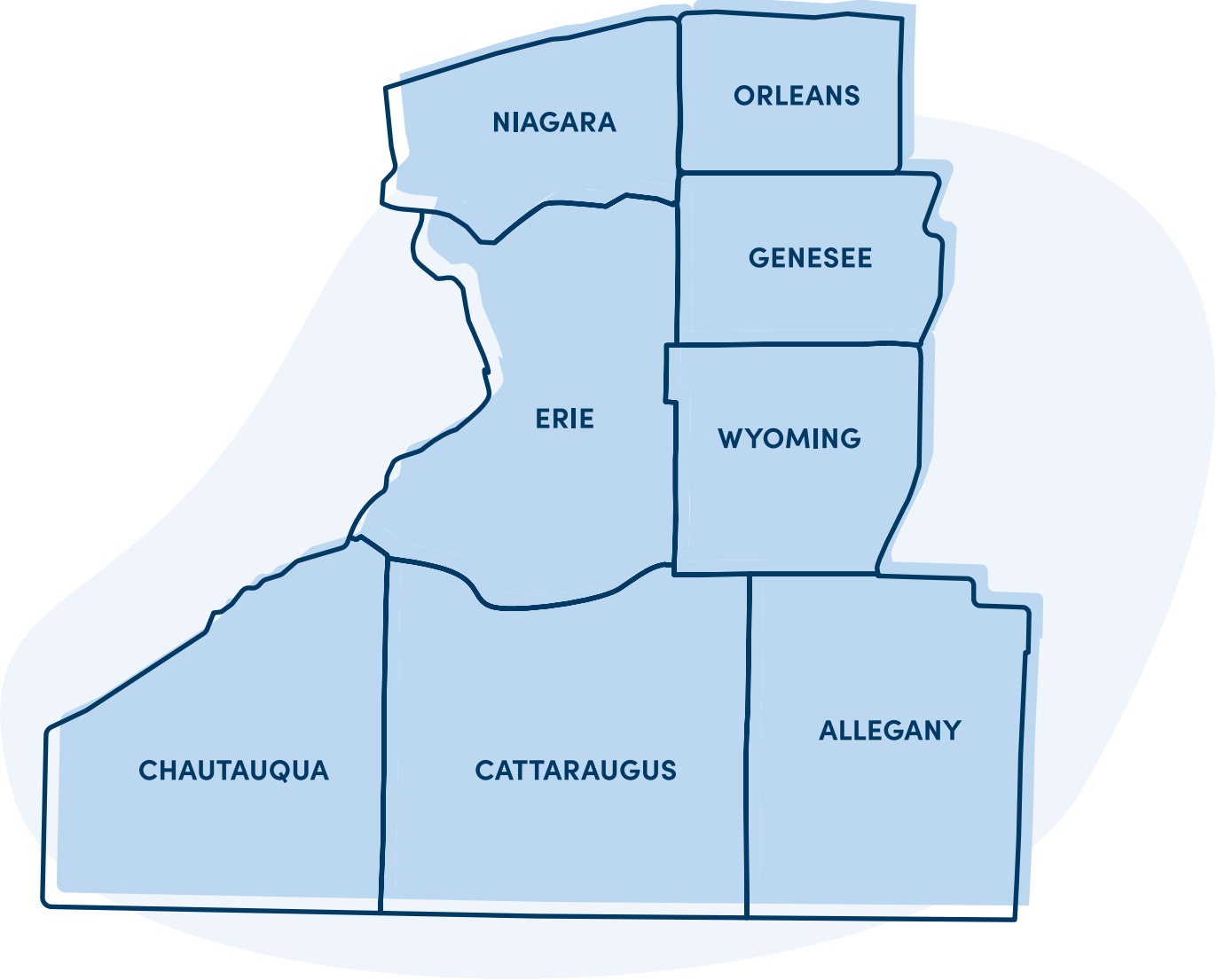
They include:

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

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

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Plans are available for residents of the counties highlighted below.



To see if your provider is in network, visit [highmark.com](https://www.highmark.com), select **Individual and Family Plans**, scroll down to **Find a Doc or Rx**, select **Just Browsing**, enter your ZIP code and click **Continue**, then scroll down and click **Medical Care**.

# Looking for plan details?

You're in the right place.

You'll see plan summaries here. If you want any plan's full benefit list, visit [highmarksbcs.com](https://highmarksbcs.com) or get a paper copy by calling 1-833-258-0188 (TTY/TDD 711).

## Coverage Level

### BRONZE STANDARD HSAQ

### BRONZE POS 8000

### SILVER STANDARD

	BRONZE STANDARD HSAQ	BRONZE POS 8000	SILVER STANDARD
<b>Plan Availability</b>	POS	POS	POS
<b>Monthly Premium</b>			
<b>Individual</b>	\$532.91	\$474.37; With adult dental and vision: \$505.36	\$720.15
<b>Individual and Children</b>	\$905.95	\$806.43; With adult dental and vision: \$859.11	\$1,224.26
<b>Individual and Spouse/ Domestic Partner</b>	\$1,065.82	\$948.74; With adult dental and vision: \$1,010.72	\$1,440.30
<b>Family</b>	\$1,518.79	\$1,351.95; With adult dental and vision: \$1,440.28	\$2,052.43
<b>In-Network Deductible</b>	Individual: \$6,100 Family: \$12,200	Individual: \$8,500 Family: \$17,000	Individual: \$2,100 Family: \$4,200
<b>In-Network, Out-of-Pocket Maximum</b>	Individual: \$7,150 Family: \$14,300	Individual: \$9,100 Family: \$18,200	Individual: \$9,450 Family: \$18,900
<b>Primary Care Visit</b>	50% after deductible	50% after deductible	\$30 after deductible One pre-deductible office visit*
<b>Specialist Visit</b>	50% after deductible	50% after deductible	\$65 after deductible
<b>Outpatient Mental Health and Substance Abuse Visits<sup>1</sup></b>	50% after deductible	50% after deductible	\$30 after deductible
<b>Speech, Physical, and Occupational Therapy and Chiropractic Care<sup>2</sup></b>	50% after deductible	50% after deductible	\$30 after deductible
<b>Diagnostic Test (Lab/X-ray)</b>	50% after deductible	50% after deductible	\$50/\$75 after deductible
<b>Urgent Care</b>	50% after deductible	50% after deductible	\$70 after deductible
<b>Emergency Services</b>	50% after deductible	50% after deductible	\$500 after deductible
<b>Hospital Inpatient (including facility and professional)<sup>3</sup></b>	50% after deductible	50% after deductible	\$1,500 after deductible
<b>Pharmacy Summary<sup>4</sup></b>	\$10/\$35/\$70 after deductible	\$15/50%/50% after deductible	\$15/\$40/\$75
<b>Includes Dental and Vision Option<sup>5</sup></b>	No	Yes	No

<sup>1</sup> Unlimited visits, 20 visits per plan year for family counseling.

<sup>2</sup> Inpatient: Limit of 60 combined physical and occupational therapy visits per benefit period for Standard plans. No visit limitations for non-Standard plans.

Outpatient: Limit of 60 combined speech, physical, and occupational visits per condition per plan year.

<sup>3</sup> For plans with a hospital inpatient copay, the copay includes all facility and professional charges. Please refer to the plan's contract for additional information.

<sup>4</sup> Visit [highmark.link/nyformulary](https://highmark.link/nyformulary) to view our Formulary and see if your drug is covered, and at which tier.

<sup>5</sup> See pages 27-31 for adult dental and vision benefit details.

\* The pre-deductible office visit benefit is available once per plan year, per member, for one of the following office visits or services: primary, specialist, or chiropractic care; allergy testing and treatment; second opinions; physical, occupational, and speech therapy; applied behavior analysis (ABA) treatment; or outpatient mental health/substance use disorder (MH/SUD) treatment.

#### Additional annual benefit limits

- Home Health Care: 40 visits per plan year
- Hearing Aids: Single purchase every three years. Members must choose hearing aids from John R. Oishei Children's Hospital or Beckes Optical and Hearing Aids. Members are entitled to discounts through TruHearing
- Hospice: 210 days per plan year; five visits per plan year for family bereavement
- Skilled Nursing Facility: Unlimited for non-Standard plans; 200 days per year for Standard plans



	Coverage Level		
	SILVER POS 7000 HSAQ	SILVER DESTINATION 65	GOLD STANDARD
Plan Availability	POS	POS	POS
Monthly Premium			
Individual	\$641.04	\$681.31	\$932.60
Individual and Children	\$1,089.77	\$1,158.23	\$1,585.42
Individual and Spouse/Domestic Partner	\$1,282.08	\$1,362.62	\$1,865.20
Family	\$1,826.96	\$1,941.73	\$2,657.91
In-Network Deductible	Individual: \$3,000 Family: \$6,000	Individual: \$2,500 Family: \$5,000	Individual: \$600 Family: \$1,200
In-Network, Out-of-Pocket Maximum	Individual: \$7,000 Family: \$14,000	Individual: \$9,450 Family: \$18,900	Individual: \$5,900 Family: \$11,800
Primary Care Visit	\$30 after deductible	\$0 after deductible	\$25 after deductible
Specialist Visit	\$50 after deductible	\$35 after deductible	\$40 after deductible
Outpatient Mental Health and Substance Abuse Visits <sup>1</sup>	\$30 after deductible	\$0 after deductible	\$25 after deductible
Speech, Physical, and Occupational Therapy and Chiropractic Care <sup>2</sup>	\$30 after deductible	\$0 after deductible	\$30 after deductible
Diagnostic Test (Lab/X-ray)	\$50 after deductible	\$0/\$125 after deductible	\$40 after deductible
Urgent Care	\$75 after deductible	\$60 after deductible	\$60 after deductible
Emergency Services	\$300 after deductible	\$300 after deductible	\$150 after deductible
Hospital Inpatient (including facility and professional) <sup>3</sup>	\$1,000 after deductible	\$750 after deductible	\$1,000 after deductible
Pharmacy Summary <sup>4</sup>	\$5/\$50/50% after deductible	\$15/\$50/50%	\$10/\$35/\$70
Includes Dental and Vision Option <sup>5</sup>	No	No	No

<sup>1</sup> Unlimited visits, 20 visits per plan year for family counseling.

<sup>2</sup> Inpatient: Limit of 60 combined physical and occupational therapy visits per benefit period for Standard plans. No visit limitations for non-Standard plans.

Outpatient: Limit of 60 combined speech, physical, and occupational visits per condition per plan year.

<sup>3</sup> For plans with a hospital inpatient copay, the copay includes all facility and professional charges. Please refer to the plan's contract for additional information.

<sup>4</sup> Visit [highmark.link/nyformulary](https://highmark.link/nyformulary) to view our Formulary and see if your drug is covered, and at which tier.

<sup>5</sup> See pages 27-31 for adult dental and vision benefit details.

	Coverage Level			
	GOLD POS 200 HSAQ	GOLD DESTINATION 65	PLATINUM STANDARD	PLATINUM POS PLUS
Plan Availability	POS	POS	POS	POS
Monthly Premium				
Individual	\$830.14	\$882.30	\$1,137.84	\$1,012.84 With adult dental and vision: \$1,055.80
Individual and Children	\$1,411.24	\$1,499.91	\$1,934.33	\$1,721.83 With adult dental and vision: \$1,794.86
Individual and Spouse/Domestic Partner	\$1,660.28	\$1,764.60	\$2,275.68	\$2,025.68 With adult dental and vision: \$2,111.60
Family	\$2,365.90	\$2,514.56	\$3,242.84	\$2,886.59; With adult dental and vision: \$3,009.03
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: \$9,450 Family: \$18,900	Individual: \$2,000 Family: \$4,000	Individual: \$6,500 Family: \$13,000
Primary Care Visit	\$20 after deductible	\$0 copay	\$15 copay	\$10 copay
Specialist Visit	\$40 after deductible	\$30 copay	\$35 copay	\$30 copay
Outpatient Mental Health and Substance Abuse Visits <sup>1</sup>	\$20 after deductible	\$0 copay	\$15 copay	\$10 copay
Speech, Physical, and Occupational Therapy and Chiropractic Care <sup>2</sup>	\$20 after deductible	\$0 copay	\$25 copay	\$10 copay
Diagnostic Test (Lab/X-ray)	\$40 after deductible	\$0/\$125 copay	\$35 copay	\$30 copay
Urgent Care	\$50 after deductible	\$60 copay	\$55 copay	\$40 copay
Emergency Services	\$300 after deductible	\$300 copay	\$100 copay	\$300 copay
Hospital Inpatient (including facility and professional) <sup>3</sup>	\$750 after deductible	\$750 copay	\$500 copay	\$500 copay
Pharmacy Summary <sup>4</sup>	\$5/\$40/50% after deductible	\$5/\$50/50%	\$10/\$30/\$60	\$5/\$30/50%
Includes Dental and Vision Option <sup>5</sup>	No	No	No	Yes

#### Additional annual benefit limits

- Home Health Care: 40 visits per plan year
- Hearing Aids: Single purchase every three years. Members must choose hearing aids from John R. Oishei Children's Hospital or Beckes Optical and Hearing Aids. Members are entitled to discounts through TruHearing
- Hospice: 210 days per plan year; five visits per plan year for family bereavement
- Skilled Nursing Facility: Unlimited for non-Standard plans; 200 days per year for Standard plans

# Vision and dental benefits

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# Plans that include adult vision and dental



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

You can find adult dental and vision benefits on pages 29–31 and pediatric dental and vision benefits on pages 33–36.

## Vision coverage

Getting your eyes checked can help identify issues like diabetes early on when they're easier to treat. Our adult vision covers a free annual eye exam.

## Dental coverage

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

## It pays to have dental coverage

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

\* Two cleanings per year.

<sup>1</sup> [https://www.dentaly.org/us/oral-hygiene/teeth-cleaning/#How\\_much\\_does\\_a\\_dental\\_cleaning\\_cost](https://www.dentaly.org/us/oral-hygiene/teeth-cleaning/#How_much_does_a_dental_cleaning_cost), last accessed April 25, 2023; <https://www.dentaly.org/us/panoramic-dental-xray/>, last accessed April 25, 2023

<sup>2</sup> [https://www.dentaly.org/us/tooth-filling/#How\\_much\\_do\\_fillings\\_cost](https://www.dentaly.org/us/tooth-filling/#How_much_do_fillings_cost), last accessed April 25, 2023

<sup>3</sup> [https://www.dentaly.org/us/tooth-extraction/#How\\_much\\_does\\_tooth\\_removal\\_cost\\_in\\_the\\_US](https://www.dentaly.org/us/tooth-extraction/#How_much_does_tooth_removal_cost_in_the_US), last accessed April 25, 2023

<sup>4</sup> <https://www.webmd.com/oral-health/guide/dental-root-canals>, last accessed April 25, 2023

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

## In-network

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

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

Eyeglass benefit - spectacle lenses	Average retail value	Member charges
Clear plastic single-vision, lined bifocal, trifocal, or lenticular lenses (any Rx)	\$60-\$120	Included
Oversize lenses	\$20	Included
Tinting of plastic lenses	\$20	\$11
Scratch-resistant coating	\$25-\$40	Included
Scratch protection plan single vision	\$60-\$120	\$20
Scratch protection plan multifocal	\$60-\$120	\$40
Polycarbonate lenses <sup>1</sup>	\$60-\$75	\$0 or \$30
Ultraviolet coating	\$25-\$30	\$12
Standard anti-reflective (AR) coating	\$50-\$70	\$35
Blue light filtering	\$25	\$15
Premium AR coating	\$65-\$90	\$48
Ultra AR coating	\$100-\$125	\$60
Standard progressive lenses	\$150-\$195	\$50
Premium progressives (varilux®, etc.)	\$195-\$225	\$90
Ultra progressive lenses	\$225-\$300	\$140
Intermediate-vision lenses	\$150-\$175	\$30
High-index lenses	\$90-\$150	\$55
Polarized lenses	\$95-\$110	\$75
Plastic photosensitive lenses	\$95-\$150	\$65

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

Contact lens benefit (in lieu of eyeglasses)		
<b>Non-collection contact lenses: materials allowance</b>		Up to \$150
<b>Collection contact lenses<sup>2</sup> (in lieu of allowance): materials</b>	Disposable	Covered in full
	Planned replacement	Covered in full
	Evaluation, fitting, and follow-up care	Included
<b>Medically necessary contact lenses (with prior approval)</b>	Materials, evaluation, fitting, and follow-up care	Included

<sup>1</sup> Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

<sup>2</sup> Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

### One-year eyeglass breakage warranty included.

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

To find a provider in the Davis Vision Network, visit [highmark.com](http://highmark.com), scroll down to **Find a Doc or Rx**, select **Just Browsing**, enter your ZIP code and click **Continue**, then scroll down and click **Vision Care**.

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

Dental Benefits			
Annual deductible per insured person	\$50 per calendar year		
Annual deductible per insured family	\$150 per calendar year		
Annual maximum per insured person	\$1,250		
Covered services:	Member pays		Elimination period
	In network	Out of network	
Oral Evaluations (exams)	\$0 copayment not subject to deductible	\$0 copayment not subject to deductible	None
Radiographs (all X-rays)	\$0 copayment not subject to deductible	\$0 copayment not subject to deductible	None
Prophylaxis (cleanings)	\$0 copayment not subject to deductible	\$0 copayment not subject to deductible	None
Palliative treatment (emergency)	\$0 copayment not subject to deductible	\$0 copayment not subject to deductible	None
Sealants	\$0 copayment not subject to deductible	\$0 copayment not subject to deductible	None
Space maintainers	\$0 copayment not subject to deductible	\$0 copayment not subject to deductible	None
Repairs of crowns, inlays, onlays, fixed partial dentures, and dentures	50% coinsurance after deductible	50% coinsurance after deductible	6 months
Basic restorative (fillings, etc.)	20% coinsurance after deductible	20% coinsurance after deductible	None
Simple extractions	20% coinsurance after deductible	20% coinsurance after deductible	6 months
Surgical extractions	50% coinsurance after deductible	50% coinsurance after deductible	6 months
Complex oral surgery	50% coinsurance after deductible	50% coinsurance after deductible	6 months
Endodontics (root canals, etc.)	50% coinsurance after deductible	50% coinsurance after deductible	6 months
General anesthesia and/or nitrous oxide and/or IV sedation	20% coinsurance after deductible	20% coinsurance after deductible	6 months

<b>Dental Benefits</b>			
<b>Covered services:</b>	<b>Member pays</b>		<b>Elimination period</b>
	<b>In network</b>	<b>Out of network</b>	
<b>Nonsurgical periodontics</b>	50% coinsurance after deductible	50% coinsurance after deductible	6 months
<b>Periodontal maintenance</b>	50% coinsurance after deductible	50% coinsurance after deductible	None
<b>Surgical periodontics</b>	50% coinsurance after deductible	50% coinsurance after deductible	6 months
<b>Crowns, inlays, onlays</b>	50% coinsurance after deductible	50% coinsurance after deductible	6 months
<b>Prosthetics (fixed partial dentures, dentures)</b>	50% coinsurance after deductible	50% coinsurance after deductible	6 months
<b>Adjustments and repairs of prosthetics</b>	50% coinsurance after deductible	50% coinsurance after deductible	None
<b>Implant services</b>	Not covered	Not covered	None
<b>Consultations</b>	\$0 copayment not subject to deductible	\$0 copayment not subject to deductible	None
<b>Orthodontics</b>	Not covered	Not covered	None

Participating dentists accept the allowed amount as payment in full. Non-participating dentists may bill you for the difference between their charge and the allowed amount paid by the contract.

All services listed may be subject to exclusions and limitations.



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

## In-network (non-standard)

Network benefit	Frequency - once every:	Members under 19 years of age
Eye examination including dilation (when professionally indicated)	12 months	\$0*
Spectacle lenses	Unlimited	\$0*
Frame	Unlimited	\$0*
Contact lens evaluation, fitting, and follow-up care (in lieu of eyeglasses)	Unlimited	\$0*

\* Subject to deductible on HSA-qualified plans.

## In-network (standard)

Network benefit	Frequency - once every:	Members under 19 years of age
Eye examination including dilation (when professionally indicated)	12 months	Platinum Standard: \$15 copayment Gold Standard: \$25 copayment after deductible Silver Standard: \$30 copayment after deductible Silver Standard A: \$30 copayment after deductible Silver Standard B: \$15 copayment after deductible Silver Standard C: \$10 copayment
Spectacle lenses	12 months	Platinum Standard: 10% coinsurance Gold Standard: 20% coinsurance after deductible Silver Standard: 30% coinsurance after deductible Silver Standard A: 25% coinsurance after deductible Silver Standard B: 10% coinsurance after deductible Silver Standard C: 5% coinsurance
Frame	12 months	Platinum Standard: 10% coinsurance Gold Standard: 20% coinsurance after deductible Silver Standard: 30% coinsurance after deductible Silver Standard A: 25% coinsurance after deductible Silver Standard B: 10% coinsurance after deductible Silver Standard C: 5% coinsurance
Contact lens evaluation, fitting, and follow-up care (in lieu of eyeglasses)	12 months	Platinum Standard: 10% coinsurance Gold Standard: 20% coinsurance after deductible Silver Standard: 30% coinsurance after deductible Silver Standard A: 25% coinsurance after deductible Silver Standard B: 10% coinsurance after deductible Silver Standard C: 5% coinsurance

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

Dental benefits	Non-HSA qualified non-standard plans	HSA qualified non-standard plans	Non-HSA qualified standard plans	HSA qualified standard plans
Contract year deductible per member	N/A	Follows in-network medical deductible	Follows in-network medical deductible	Follows in-network medical deductible
Annual maximum per member	N/A	N/A	N/A	N/A
Out-of-pocket year maximum per member	Follows in-network medical out-of-pocket maximum	Follows in-network medical out-of-pocket maximum	Follows in-network medical out-of-pocket maximum	Follows in-network medical out-of-pocket maximum
Network	Elite Prime	Elite Prime	Elite Prime	Elite Prime
Covered services	Member pays at participating dentists			
Oral evaluations (exams)	\$25 copay	\$25 copay	Platinum Standard: \$15 copay Gold Standard: \$25 copay after deductible Silver Standard: \$30 copay after deductible Silver Standard A: \$30 copay after deductible Silver Standard B: \$15 copay after deductible Silver Standard C: \$10 copay	50% coinsurance after deductible
Radiographs (all X-rays)	\$25 copay	\$25 copay		50% coinsurance after deductible
Prophylaxis (cleanings)	\$25 copay	\$25 copay		50% coinsurance after deductible
Fluoride treatments	\$25 copay	\$25 copay		50% coinsurance after deductible
Sealants	\$25 copay	\$25 copay		50% coinsurance after deductible
Space maintainers	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
Crowns, crown repair, inlays, and onlays	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
Basic restorative (anterior composite, anterior amalgam, and posterior amalgam)	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
Simple extractions	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
Surgical extractions	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
Oral surgery	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
Apicoectomy/periradicular surgery	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible

Dental benefits	Non-HSA qualified non-standard plans	HSA qualified non-standard plans	Non-HSA qualified standard plans	HSA qualified standard plans
<b>Network</b>	<b>Elite Prime</b>	<b>Elite Prime</b>	<b>Elite Prime</b>	<b>Elite Prime</b>
<b>Consultations</b>	50% coinsurance	50% coinsurance after deductible	Platinum Standard: \$15 copay Gold Standard: \$25 copay after deductible Silver Standard: \$30 copay after deductible Silver Standard A: \$30 copay after deductible Silver Standard B: \$15 copay after deductible Silver Standard C: \$10 copay	50% coinsurance after deductible
<b>General anesthesia, nitrous oxide and/or IV sedation</b>	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
<b>Palliative treatment (emergency)</b>	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
<b>Endodontics (root canals, etc.)</b>	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
<b>Surgical periodontics</b>	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
<b>Periodontal maintenance</b>	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
<b>Prosthodontics (fixed partial dentures)</b>	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
<b>Prosthetics (complete dentures, adjustments, and repairs)</b>	50% coinsurance	50% coinsurance after deductible		50% coinsurance after deductible
<b>Implant services</b>	Not covered			
<b>Maxillofacial prosthetics</b>	50% coinsurance	50% coinsurance after deductible	Platinum Standard: \$15 copay Gold Standard: \$25 copay after deductible Silver Standard: \$30 copay after deductible	50% coinsurance after deductible
<b>Medically necessary orthodontics</b>	50% coinsurance	50% coinsurance after deductible	Silver Standard A: \$30 copay after deductible Silver Standard B: \$15 copay after deductible Silver Standard C: \$10 copay	50% coinsurance after deductible
<b>Cosmetic orthodontic services</b>	Not covered			

Participating dentists accept the allowed amount as payment in full. Non-participating dentists may bill you for the difference between their charge and the allowed amount paid by the contract.

All services listed may be subject to exclusions and limitations.

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# Health care lingo, translated.

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

## **BLUECARD**

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

## **COINSURANCE**

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

## **COPAY**

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

## **DEDUCTIBLE**

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

## **EMERGENCY SERVICES**

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

## **FORMULARY**

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

## **HABILITATIVE SERVICES**

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

## **HEALTH SAVINGS ACCOUNT (HSA)**

An account to set aside pre-tax money to pay for qualified medical expenses. You can only have an HSA if you have a qualified high-deductible health plan.

## **HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)**

A plan that usually comes with a lower premium because you pay more for health care services upfront before the insurance company starts to pay. Qualified high-deductible health plans are often combined with a health savings account.

## **IN-NETWORK PROVIDER**

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

## **NON-PARTICIPATING PROVIDER**

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

## **OUT-OF-POCKET MAXIMUM**

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

## **PLAN ALLOWANCE**

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

## **PREMIUM**

The monthly amount paid for coverage.

## **PREVENTIVE CARE SERVICES**

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

## **PRIMARY CARE PROVIDER (PCP)**

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

## **QUALIFIED HEALTH PLAN (QHP)**

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

## **REHABILITATIVE SERVICES**

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

## **RETAIL CLINIC**

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

## **URGENT CARE CENTER**

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

## **VIRTUAL VISIT**

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

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

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## Important Benefit Details

**Non-Embedded Family Deductible:** For an agreement covering more than one (1) family member, the family deductible must be satisfied before the plan will begin to pay benefits for covered services for any covered family member. When the family deductible has been satisfied, the family deductible will be considered to have been satisfied for all family members, the plan will begin to pay benefits for covered services for all covered family members for the remainder of the benefit period (January 1, 2024– December 31, 2024). The family deductible can be met by one family member or a combination of members.

**Aggregate/Embedded Family Deductible Plans:** For an Agreement covering more than one (1) family member, as each Member satisfies their individual Deductible, the Plan will begin to pay benefits for Covered Services for that Member for the remainder of the Benefit Period (January 1, 2024– December 31, 2024), whether or not the entire family Deductible has been satisfied. When the family Deductible has been satisfied, the family Deductible will be considered to have been satisfied for all remaining covered family members. Not every individual member must meet the individual deductible for the family deductible to be met and no individual member may satisfy the entire family Deductible.

You are responsible for out-of-pocket costs each benefit period (January 1, 2024– December 31, 2024) up to the maximum amount shown. Thereafter, the plan pays 100% of the Plan Allowance. During the remainder of the benefit period. This amount does not include amounts in excess of the plan allowance.

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

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

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

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

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

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

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

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

## Highmark Disclosures

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

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

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

Highmark Blue Cross Blue Shield is a Qualified Health Plan insurer in the New York Insurance Exchange.

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

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

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

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 2024.

My Care Navigator is a service mark of Highmark Inc.

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

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

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield, is an independent licensee of the Blue Cross Blue Shield Association.

### 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>.

### For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר היילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں۔

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لیے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Perassistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k' ehjí yá ' áti ' bee shíká adoowot nohsingo naaltsoos nihaa halne ' go nidaahntinígíí bine ' déé ' Customer Service bibéesh bee hane ' é biká'ígíí bich ' j ' dahodootnih.

# Ready to (en)roll?

## Cool. Here's how to do it:

- By phone: 1-855-355-5777
- Online: [nystateofhealth.ny.gov](http://nystateofhealth.ny.gov)
- By contacting your agent or broker



Because Life.™