

2016 Health Insurance  
**Plan Comparison Guide**



Available through the Health Insurance Marketplace  
for Individuals and Families

BENEFIT PERIOD: JANUARY 1, 2016 TO DECEMBER 31, 2016

# 2016 HIGHMARK PLANS

Highmark Plans listed are available through the Marketplace in the Following Counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre\*, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, Westmoreland

Plan Name	Shared Cost Blue PPO 6000	Health Savings Blue PPO Embedded 4500	Health Savings Blue PPO Embedded 2700	Health Savings Blue PPO 1400
Plan ID	70194PA0140001-01	70194PA0150001-01	70194PA0150003-01	70194PA0150005-01
Network	KEYSTONE HEALTH PLAN WEST NETWORK			
Metal Level	BRONZE	BRONZE	SILVER	GOLD
Deductible (Individual)	\$6,000	\$4,500	\$2,700	\$1,400
Deductible (Family) <sup>1,2</sup>	\$12,000	\$9,000	\$5,400	\$2,800
Out-of-Pocket Maximum (Individual) <sup>3</sup>	\$6,850	\$6,450	\$5,400	\$2,800
Out-of-Pocket Maximum (Family)	\$13,700	\$12,900	\$10,800	\$5,600
Coinsurance (Plan Pays)	60% after deductible	70% after deductible	90% after deductible	90% after deductible
Primary Care Visit	100% after \$80 copay, no deductible	70% after deductible	90% after deductible	90% after deductible
Specialist or Urgent Care Visit	100% after \$125 copay, no deductible	70% after deductible	90% after deductible	90% after deductible
Emergency Room Visit	60% after deductible	70% after deductible	90% after deductible	90% after deductible
Inpatient Hospital Services	60% after deductible	70% after deductible	90% after deductible	90% after deductible
Diagnostic Lab <sup>7</sup>	100% after \$75 copay, no deductible	70% after deductible	90% after deductible	90% after deductible
Prescription Formulary	HCR Comprehensive <sup>6</sup>	HCR Comprehensive <sup>6</sup>	HCR Comprehensive <sup>6</sup>	HCR Comprehensive <sup>6</sup>
Prescription Drug Coverage – Retail Generic/Brand/ Non-Formulary (Member Pays)	40% after deductible	30% after deductible	10% after deductible	10% after deductible
Specialty Pharmacy – Retail Brand/ Non-Formulary (Member Pays)	40% after deductible	30% after deductible	10% after deductible	10% after deductible
Pediatric Vision Services	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay
Pediatric Dental Services (Diagnostic & Preventive)	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay

\*HCR Progressive Formulary offers \$3 low-cost generic drugs.

\*\*Note: You must reside in one of the following ZIP codes in Centre County to enroll in one of these plans – 16666, 16686, 16829, 16845, 16859, 16860, 16874, 16877



Do you need adult dental insurance? Highmark Blue Edge Dental offers a level of coverage that will fit your budget. Visit [HighmarkBlueEdgeDental.com](http://HighmarkBlueEdgeDental.com) to find out more.

# 2016 HIGHMARK PLANS

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Plan Name	Comprehensive Care Blue PPO 1500	Comprehensive Care Flex Blue PPO 500	Blue Cross Blue Shield Shared Cost 3200, a Multi-State Plan	Blue Cross Blue Shield Shared Cost 1500, a Multi-State Plan
Plan ID	70194PA0160001-01	70194PA0280002-01	70194PA0130001-01	70194PA0130002-01
Network	KEYSTONE HEALTH PLAN WEST NETWORK			
Metal Level	SILVER	PLATINUM	SILVER	GOLD
Deductible (Individual)	\$1,500	\$500 (enhanced); \$1,500 (standard)	\$3,200	\$1,500
Deductible (Family) <sup>1,2</sup>	\$3,000	\$1000 (enhanced); \$3,000 (standard)	\$6,400	\$3,000
Out-of-Pocket Maximum (Individual) <sup>3</sup>	\$6,850	\$1,650 Enhanced and Standard Combined	\$6,350	\$4,000
Out-of-Pocket Maximum (Family)	\$13,700	\$3,300 Enhanced and Standard Combined	\$12,700	\$8,000
Coinsurance (Plan Pays)	80% after deductible	90% after deductible (Enhanced); 60% after deductible (Standard)	80% after deductible	90% after deductible
Primary Care Visit	Deductible then 100% after \$35 copay	90% after deductible (Enhanced); 60% after deductible (Standard)	100% after \$30 copay, no deductible	100% after \$20 copay, no deductible
Specialist or Urgent Care Visit	Deductible then 100% after \$70 copay	90% after deductible (Enhanced); 60% after deductible (Standard)	100% after \$70 copay, no deductible	100% after \$40 copay, no deductible
Emergency Room Visit	80% after deductible	90% after deductible	80% after deductible	90% after deductible
Inpatient Hospital Services	80% after deductible	90% after deductible (Enhanced); 60% after deductible (Standard)	80% after deductible	90% after deductible
Diagnostic Lab <sup>7</sup>	Deductible then 100% after \$40 copay	90% after deductible (Enhanced); 60% after deductible (Standard)	100% after \$40 copay, no deductible	100% after \$20 copay, no deductible
Prescription Formulary	HCR Progressive* <sup>4</sup>	HCR Comprehensive <sup>6</sup>	HCR Progressive* <sup>4</sup>	HCR Progressive* <sup>4</sup>
Prescription Drug Coverage – Retail Generic/Brand/ Non-Formulary (Member Pays)	\$10 copay; \$50 copay; \$100 copay	\$5 copay; \$20 copay; \$45 copay, no deductible	\$10 copay; \$50 copay; \$100 copay	\$10 copay; \$50 copay; \$100 copay
Specialty Pharmacy – Retail Brand/ Non-Formulary (Member Pays)	50% with \$600 max per prescription; 50% up to \$1,000 max per prescription	50% with \$500 max per prescription; 50% up to \$750 max per prescription	50% with \$600 max per prescription; 50% up to \$1,000 max per prescription	50% with \$600 max per prescription; 50% up to \$1,000 max per prescription
Pediatric Vision Services	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay
Pediatric Dental Services (Diagnostic & Preventive)	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay

\*HCR Progressive Formulary offers \$3 low-cost generic drugs.

\*\*Note: You must reside in one of the following ZIP codes in Centre County to enroll in one of these plans – 16666, 16686, 16829, 16845, 16859, 16860, 16874, 16877

# 2016 CONNECT BLUE PLANS

Plans on this page only available in the following counties: Allegheny, Beaver, Butler, Washington, Westmoreland, Erie

Plan Name	Connect Blue EPO 5500 a Community Blue Plan	Connect Blue EPO 2500 a Community Blue Plan	Connect Blue EPO 750 a Community Blue Plan	Connect Blue EPO 250 a Community Blue Plan
Plan ID	33709PA0690004-01	33709PA0690002-01	33709PA0690001-01	33709PA0690003-01
Network	COMMUNITY BLUE NETWORK			
Metal Level	BRONZE	SILVER	SILVER	GOLD
Deductible (Individual)	\$5,500 (Preferred); \$6,500 (Enhanced); \$6,850 (Standard)	\$2,500 (Preferred); \$4,000 (Enhanced); \$6,000 (Standard)	\$750 (Preferred); \$4,000 (Enhanced); \$6,000 (Standard)	\$250 (Preferred); \$750 (Enhanced); \$2,250 (Standard)
Deductible (Family) <sup>1,2</sup>	\$11,000 (Preferred); \$13,000 (Enhanced); \$13,700 (Standard)	\$5,000 (Preferred); \$8,000 (Enhanced); \$12,000 (Standard)	\$1,500 (Preferred); \$8,000 (Enhanced); \$12,000 (Standard)	\$500 (Preferred); \$1,500 (Enhanced); \$4,500 (Standard)
Out-of-Pocket Maximum (Individual) <sup>3</sup>	\$6,850 Combined All Tiers	\$6,850 Combined All Tiers	\$6,850 Combined All Tiers	\$6,850 Combined All Tiers
Out-of-Pocket Maximum (Family)	\$13,700 Combined All Tiers	\$13,700 Combined All Tiers	\$13,700 Combined All Tiers	\$13,700 Combined All Tiers
Coinsurance (Plan Pays)	70% after deductible (Preferred); 50% after deductible (Enhanced); 40% after deductible (Standard)	90% after deductible (Preferred); 70% after deductible (Enhanced); 50% after deductible (Standard)	70% after deductible (Preferred); 50% after deductible (Enhanced); 40% after deductible (Standard)	90% after deductible (Preferred); 70% after deductible (Enhanced); 50% after deductible (Standard)
Primary Care Visit	100% after \$65 copay, no deductible (Preferred); 100% after \$110 copay, no deductible (Enhanced); 40% after deductible (Standard)	100% after \$30 copay, no deductible (Preferred); 100% after \$50 copay, no deductible (Enhanced); 50% after deductible (Standard)	100% after \$25 copay, no deductible (Preferred); 100% after \$70 copay, no deductible (Enhanced); 40% after deductible (Standard)	100% after \$10 copay, no deductible (Preferred); 100% after \$40 copay, no deductible (Enhanced); 50% after deductible (Standard)
Specialist Visit	100% after \$100 copay, no deductible (Preferred); 100% after \$160 copay, no deductible (Enhanced); 40% after deductible (Standard)	100% after \$45 copay, no deductible (Preferred); 100% after \$90 copay, no deductible (Enhanced); 50% after deductible (Standard)	100% after \$80 copay, no deductible (Preferred); 100% after \$100 copay, no deductible (Enhanced); 40% after deductible (Standard)	100% after \$40 copay, no deductible (Preferred); 100% after \$65 copay, no deductible (Enhanced); 50% after deductible (Standard)
Urgent Care Visit	100% after \$100 copay, no deductible (Preferred); 100% after \$100 copay, no deductible (Enhanced); 40% after deductible (Standard)	100% after \$45 copay, no deductible (Preferred); 100% after \$45 copay, no deductible (Enhanced); 50% after deductible (Standard)	100% after \$80 copay, no deductible (Preferred); 100% after \$80 copay, no deductible (Enhanced); 40% after deductible (Standard)	100% after \$40 copay, no deductible (Preferred); 100% after \$40 copay, no deductible (Enhanced); 50% after deductible (Standard)
Emergency Room Visit	70% after Preferred deductible, waived if admitted	100% after \$500 Copay, waived if admitted	100% after \$500 Copay, waived if admitted	100% after \$600 Copay, waived if admitted
Inpatient Hospital Services	\$1,500 copay, per admission, then 100% (Preferred); 50% after deductible (Enhanced); 40% after deductible (Standard)	\$500 copay per day, 3 day max then 100% (Preferred); \$1,000 copay per day, 3 day max then 100% (Enhanced); 50% after deductible (Standard)	\$1,000 copay per day, 3 day max then 100% (Preferred); \$1,500 copay per day, 3 day max then 100% (Enhanced); 40% after deductible (Standard)	\$500 copay per day, 3 day max then 100% (Preferred); \$1,000 copay per day, 3 day max then 100% (Enhanced); 50% after deductible (Standard)
Diagnostic Lab <sup>7</sup>	100% after \$60 copay, no deductible (Preferred); 100% after \$110 copay, no deductible (Enhanced); 40% after deductible (Standard)	100% after \$45 copay, no deductible (Preferred); 100% after \$90 copay, no deductible (Enhanced); 50% after deductible (Standard)	100% after \$80 copay, no deductible (Preferred); 100% after \$120 copay, no deductible (Enhanced); 40% after deductible (Standard)	100% after \$40 copay, no deductible (Preferred); 100% after \$65 copay, no deductible (Enhanced); 50% after deductible (Standard)
Prescription Formulary	HCR Comprehensive <sup>6</sup>	HCR Progressive <sup>**4</sup>	HCR Progressive <sup>**4</sup>	HCR Progressive <sup>**4</sup>
Prescription Drug Coverage – Retail Generic/Brand/Non-Formulary (Member Pays)	30% after deductible	\$10 Copay; \$50 Copay; \$100 copay	\$10 Copay; \$50 Copay; \$100 copay	\$10 Copay; \$50 Copay; \$100 copay
Specialty Pharmacy – Retail Brand/Non-Formulary (Member Pays)	30% after deductible	50% coinsurance with \$500 max per prescription; 50% up to \$750 max per prescription	50% coinsurance with \$500 max per prescription; 50% up to \$750 max per prescription	50% coinsurance with \$500 max per prescription; 50% up to \$750 max per prescription
Pediatric Vision Services <sup>5</sup>	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay
Pediatric Dental Services (Diagnostic & Preventive)	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay	100%, no deductible or copay

\*HCR Progressive Formulary offers \$3 low-cost generic drugs.

# DISCLOSURE

## Important Benefit Details

<sup>1</sup>Flex, Shared Cost and Health Savings Embedded and Comprehensive Care 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, 2016 – December 31, 2016), 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.

<sup>2</sup>Health Savings and Major Events Family Deductible: For an Agreement covering more than one (1) family member, the ENTIRE family deductible must be met [within a benefit period (January 1, 2016 – December 31, 2016)] 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.

<sup>3</sup>You are responsible for out-of-pocket costs each Benefit Period up to a 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.

<sup>4</sup>HCR Progressive Formulary prescription drug copays for a 31-day supply (Retail): \$3 low-cost generic; \$10 generic; \$50 brand; \$100 non-formulary brand and non-formulary generic; specialty drug copays vary. The plan has a six-tier structure and utilizes the HCR Progressive Formulary on the National network. Mail order available. If a generic substitution is available but not accepted by the Member they are responsible for paying the difference between the price for a Brand Drug and any available generic equivalent, for each separate Prescription Order or refill plus the drug copay.

<sup>5</sup>Vision benefits utilize the Davis National Network. Pediatric Dental benefits utilize United Concordia's Advantage Network

<sup>6</sup>The plan utilizes the HCR Comprehensive Formulary on the National network. Specialty drug copays may vary. Mail order available.

<sup>7</sup>Basic Diagnostic Services include four types of service: Standard Imaging Services, Laboratory and Pathology, Diagnostic Medical and Allergy Testing. Basic Diagnostic Services require one copay per date of service and type of service. Additional Basic Diagnostic Services are subject to deductible and coinsurance. Advanced Diagnostic Services include but are not limited to CAT Scan, CTA, MRI, MRA, PET Scan and PET/CT Scan.

Health Savings Plans are Qualified High Deductible Health Plans that 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.

Multi-State Plans are only available for enrollment through the Health Insurance Marketplace.

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Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Choice Company.

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association. Highmark is a registered mark of Highmark Inc. 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. State laws may be applicable. 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. Federal and state laws and regulations govern health insurance and health plans may vary from state to state. Highmark Blue Cross Blue Shield does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations. We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call us at 1-855-329-0746 to request these free services (TTY/TDD users may call 711).

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](http://DiscoverHighmark.com/QualityAssurance); or for a paper copy, call 1-855-873-4106.

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

Blues On Call and Blue Card are service marks of the Blue Cross and Blue Shield Association.

My Care Navigator<sup>SM</sup> is a service mark of Highmark Inc.

*Access to UPMC Providers for 2016: As of November 2015, Highmark members who are in the midst of a course of treatment for a chronic/persistent condition in 2014 or 2015 with a UPMC provider will continue to have in-network access to that provider for 2016. Additionally, members who have been treated by a UPMC physician for pregnancy in 2015, are eligible to deliver at Magee-Womens Hospital in 2016. To learn more visit [DiscoverHighmark.com/ConsentWP](http://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 2016.*



If you are looking for additional plan details, each plan's Summary of Benefits and Coverage is available online at [HighmarkBCBS.com/sbc/bcbs.html](http://HighmarkBCBS.com/sbc/bcbs.html). With this information, you'll be able to shop and compare with confidence. 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 1-855-329-0746.

# COMMITTED TO PROVIDING OUTSTANDING SERVICE

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call us at 1-855-329-0746 to request these free services. (TTY/TDD: 711)

Estamos comprometidos a ofrecer servicios excepcionales a nuestros solicitantes y miembros. Si usted necesita ayuda especial, incluyendo acomodaciones para discapacidades o dominio limitado del inglés, por favor llámenos al 1-855-329-0746 para solicitar estos servicios gratuitos. (TTY/TDD: 711)

Wir haben uns verpflichtet, unseren Bewerbern und Mitgliedern außerordentliche Dienstleistungen anzubieten. Falls Sie beispielsweise Unterkünfte für Menschen mit Behinderungen oder aufgrund eingeschränkter Englischkenntnisse besondere Unterstützung benötigen, kontaktieren Sie uns unter der Rufnummer 1-855-329-0746, um unsere kostenlosen Dienstleistungen in Anspruch zu nehmen. (TTY/TDD: 711)

Ci impegniamo a fornire sempre servizi all'avanguardia per i nostri candidati e membri. In caso necessitate di assistenza speciale, compresi alloggi per disabili o supporto per la scarsa padronanza della lingua inglese, contattateci allo 1-855-329-0746 per richiedere gratuitamente tali servizi. (TTY/TDD: 711)

我們致力於為我們的申請人和會員們提供卓越的服務。如果您需要特殊協助，包括殘障或英語能力有限，請致電 1-855-329-0746 來要求這些免費服務。(TTY/TDD: 711)

Nous nous engageons à fournir des services exceptionnels pour nos candidats et membres. Si vous avez besoin d'une assistance particulière, y compris pour handicapés ou compétences limitées en anglais, s'il vous plaît appelez-nous au 1-855-329-0746 pour demander ces services gratuits. (TTY/TDD: 711)

Мы стремимся оказывать первоклассные услуги для наших кандидатов и членов. Если вы нуждаетесь в специальной помощи, включая принятие мер в связи с инвалидностью или ограниченным владением английским языком, пожалуйста, позвоните нам по телефону 1-855-329-0746 и попросите об оказании этих бесплатных услуг. (TTY/TDD: 711)

Chúng tôi quyết tâm cung cấp dịch vụ xuất sắc cho các đương đơn và hội viên của mình. Nếu quý vị cần được trợ giúp đặc biệt, bao gồm các thích nghi cho người bị khuyết tật hoặc có khả năng Anh Ngữ hạn hẹp, xin gọi chúng tôi tại số 1-855-329-0746 để yêu cầu các dịch vụ miễn phí này. (TTY/TDD: 711)

Zależy nam, aby usługi, które świadczymy dla naszych kandydatów i członków charakteryzowały się zawsze najwyższą jakością. Jeżeli potrzebna jest specjalna pomoc, np. w przypadku osób niepełnosprawnych lub osób z ograniczoną znajomością języka angielskiego, oferujemy bezpłatne usługi w tym zakresie – prosimy o telefon pod numer 1-855-329-0746. (TTY/TDD: 711)

저희들은 신청자들과 회원들에게 탁월한 서비스를 제공하고자 노력하고 있습니다. 신체장애인들이나 비영어권 참석자들을 위해 특별한 도움이 필요하시면 전화 1-855-329-0746 로 알려주시기 바랍니다. 이러한 서비스는 무료입니다. (TTY/TDD: 711)

نلتزم بتوفير خدمة متميزة للمتقدمين والأعضاء. إذا كنت تتطلب مساعدة خاصة، شاملاً التجهيزات اللازمة للاحتياجات الخاصة أو إجابة محدودة للإنجليزية، برجاء الاتصال على 1-855-329-0746 لطلب هذه الخدمات المجانية. (TTY/TDD: 711)

हम अपने आवेदकों और सदस्यों के लिए उत्कृष्ट सेवाएं प्रदान करने के प्रति वचनबद्ध हैं। यदि आपको विशेष सहायता चाहिए हो, जिसमें अक्षमता अथवा सीमित अंग्रेजी निपुणता हेतु समायोजन भी शामिल हैं, तो कृपया इन निशुल्क सेवाओं हेतु अनुरोध के लिए हमें 1-855-329-0746 पर कॉल करें।(TTY/TDD: 711)

# COMMITTED TO PROVIDING OUTSTANDING SERVICE

અમે અમારા અરજીકર્તાઓ અને સભ્યો માટે ઉમદા સેવાઓ પૂરી પાડવા કટિબદ્ધ છીએ. જો તમને વિકલાંગતા કે અંગ્રેજીમાં મર્યાદિત નિપુણતા ધરાવનારાઓ માટે સગવડભરી ગોઠવણો સહિતની વિશેષ સહાયતા જોઈતી હોય, તો આ મફત સેવાઓની વિનંતી કરવા કૃપા કરી અમને 1-855-329-0746 નંબર પર ફોન કરો. (TTY/TDD: 711)

May pananagutan kaming magbigay ng bukod-tanging mga serbisyo para sa aming mga aplikante at mga miyembro. Kung kailangan mo ng espesyal na tulong, kabilang ang mga akomodasyon para sa mga kapansanan o limitadong kahusayan sa wikang Ingles, mangyaring tawagan kami sa 1-855-329-0746 para hilingin ang mga libreng serbisyonang ito. (TTY/TDD: 711)

Είμαστε δεσμευμένοι να παρέχουμε εξαιρετικές υπηρεσίες για τους αιτούντες και τα μέλη μας. Εάν χρειάζεστε ειδική βοήθεια, συμπεριλαμβανομένων διευκολύνσεων για ειδικές ανάγκες ή περιορισμένη ευχέρεια στα Αγγλικά, παρακαλούμε επικοινωνήστε μαζί μας στο 1-855-329-0746 να ζητήσετε τις δωρεάν αυτές παροχές. (TTY/TDD: 711)

私たちは入会志願者とメンバーのために卓越したサービスを提供することに全力を注いでいます。あなたが、障害者のための便宜または制限英語能力を含む特別な支援が必要な場合は、これらの無料サービスを受けるために、1-855-329-0746までお電話ください。(TTY/TDD: 711)

ہم اپنے درخواست دہندگان اور ممبران کے لیے عمدہ خدمات فراہم کرنے کے لیے عہد بستہ ہیں۔ اگر آپ کو خصوصی اعانت کی ضرورت ہے، جس میں معذوریوں یا انگریزی کی محدود لیاقت کے لیے سہولیات شامل ہیں، ان مفت خدمات کی درخواست کرنے کے لیے براہ کرم ہمیں 1-855-329-0746 پر کال کریں۔ (TTY/TDD: 711)

Estamos empenhados em fornecer serviços especiais para os nossos candidatos e membros. Caso necessite de assistência especial, incluindo alojamento por motivos de deficiência ou conhecimentos limitados de língua inglesa, ligue para o n.º 1-855-329-0746 para solicitar estes serviços gratuitos. (TTY/TDD: 711)

Ebe fun awon alaabo ara tabi oore ofe lati le so ede geesi to se gbo seti. Ejowo e pe wa 1-855-329-0746 fun eyikeyi ohun ti e ba nfe ki a se fun yin lofe. (TTY/TDD: 711)

Sisi ni nia ya kutoa huduma bora kwa waombaji wetu na wanachama. Kama unahitaji msaada maalum, ikiwa ni pamoja na malazi kwa ulemavu au mdogo Kiingereza duni, tafadhali wito wetu katika idadi ya 1-855-329-0746 kuomba huduma hizi bure. (TTY/TDD: 711)





Nihinaanish niizhónígo bee nihiká' adiilwońgíí binahji' ts'ídá yéego bidiilkaal, nihí naaltsoos nidahoníńgíí dóó Bee Atah ídlíníńgíí nihí hada'dít'éhíńgíí nihá. Hait'éego da anáhóót'i'go, bilagáana bizaad t'áa nił nanit'ago, áká'a'ayeed holó, kóji' béesh beehane'é bee hodíłnih 1-855-329-0746, éí t'áa jíík'eh áká'a'ayeed biniyíe. (TTY/TDD: 711)

เรามุ่งมั่นที่จะมอบบริการที่โดดเด่นให้แก่ผู้สมัครและสมาชิกของเรา หากคุณต้องการความช่วยเหลือเป็นพิเศษ รวมถึงการอำนวยความสะดวกให้แก่บุคคลทุพพลภาพหรือผู้ที่มีความสามารถทางภาษาอังกฤษในระดับอ่อน โปรดติดต่อเราได้ที่ 1-855-329-0746 เพื่อร้องขอบริการดังกล่าวได้โดยไม่มีค่าใช้จ่าย (TTY/TDD: 711)



120 Fifth Avenue Place  
Pittsburgh, PA 15222

## There are many ways for you to enroll.

-  **Call** 1-855-329-0746 (TTY/TTD 711) and talk directly to a Highmark representative who can answer your questions. Or, call the Health Insurance Marketplace 24/7 at 1-800-318-2596 (TTY: 1-855-889-4325).
-  **Enroll** on the Marketplace day or night at HealthCare.gov for a Highmark plan.
-  **Visit** a local Highmark Direct store.
-  **Talk** to your local Highmark insurance agent.



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