Highmark is different in all the ways that matter most.

Benefits, perks, and access to care you won't find in other plans.

HIGHMARK.

Because Life.™

Hi there,

We know that your Medicare plan is about more than health care. It's also about peace of mind. When you choose Highmark Blue Shield, you can feel confident that we'll be there when you need us. Highmark is part of a network that's been providing secure and stable coverage for more than 70 years. And with 1 in 3 Americans covered by our network, you're in good company.*

You get more with Highmark.

Our plans offer a lot more than a great network. In this booklet, we'll walk you through some of our most popular benefits and perks so you can see how easy it is to access care and stay on top of your health. You'll also find plan descriptions and enrollment materials.

Reach out if you need help.

Please call us if you have any questions about your plan options.
1-855-215-9239 (TTY 711)
We're available Monday – Friday, 8 a.m. – 4:30 p.m.

CASHIC-Schalmont CSD
10728335 - Forever Blue 799 (PPO) Plan DNU7 TRx (OOA)

*Blue Cross and Blue Shield Association, bcbs.com

Table of Contents

Finding care

Finding care

Our Medicare Advantage plans connect you to the doctors and hospitals you trust. When you choose Highmark, you get the security of carrying a card accepted by the region's leading health systems and medical practices, including:

- **Albany Medical Center**
- **CapitalCare Medical Group**
- **Community Care Physicians P.C.**
- **Ellis Hospital**
- **Glens Falls Hospital**
- **Hudson Headwaters Health Network**
- **Irongate Family Practice**
- **Samaritan Hospital**
- **Saratoga Hospital**
- **St. Peter's Health Partners**

If you need emergency or urgent care, you can feel safe knowing that you're covered at home or on the go. Just show your member ID card and you'll receive care at any hospital in the world.

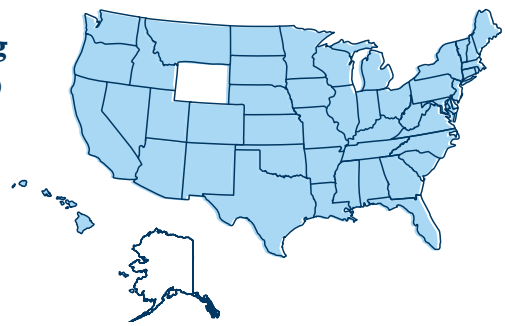
PPO plans

With our PPO (Preferred Provider Organization) plans, you have in-network access to doctors and hospitals close to home and across the country for all plan-covered services.

When you're traveling in the U.S.

In order for services outside your service area to be considered in network, the provider must participate with the local Medicare Advantage PPO network-sharing program.

You can find participating Medicare Advantage PPO providers in 49 states and two territories:



AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MS, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, PR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI.

To find out if a doctor participates in the Medicare Advantage PPO network sharing program, call **1-800-810-BLUE (2583) option 2** or visit medicare.highmark.com.

When you're traveling outside the U.S.

If you need urgent or emergency care when you're in another country, you're covered. You may be asked to pay 100% of the cost at the time of service. You would then submit a claim to be reimbursed for your share of the cost.

Supplemental benefits

Dental allowance

If you're enrolled in a plan that offers this benefit, you can use these dollars toward certain dental services, including:

- Cleanings
- Periodontal cleanings
- Crowns
- Fillings

You can go to any dentist you want for care. You'll pay upfront, then complete a dental reimbursement form. You mail that to us, along with your itemized bill and receipt. Reimbursement usually takes four to six weeks.

If you already have dental insurance, you can use the allowance for copays and coinsurance related to your care.

If you have any questions, please call 1-800-329-2792 (TTY 711)
October 1 – March 31, 8 a.m. – 8 p.m. seven days a week
April 1 – September 30, 8 a.m. – 8 p.m., Monday - Friday

Vision coverage

Cost-saving vision benefits — and access to Davis Vision providers — keep you seeing and looking your best.

Every Highmark Medicare Advantage plan covers:

- **Annual routine eye exam***
- **Glasses or contacts after cataract surgery***
- **Glaucoma screening**
- **Diagnostic eye exam**
- **Diabetic retinal exam**

Vision allowance

If you're enrolled in a plan that offers this benefit, you can use these dollars to buy certain products.

Most Highmark Medicare Advantage plan covers:

- **Contacts**
- **Frames**
- **Lens enhancements** (antireflective coating, tint, scratch-resistance)

You can use your vision allowance at these Davis Vision providers:*

- **America's Best Contacts & Eyeglasses**
- **Visionworks**
- **Walmart**

For more information and to find a provider near you, visit **DavisVision.com** or contact Davis Vision at: **1-800-999-5431 (TTY 711)**

Monday – Friday 8 a.m. – 11 p.m.
Saturday 9 a.m. – 4 p.m.
Sunday noon – 4 p.m.

* You must use a Davis Vision provider in order for coverage to be considered in network.

Hearing coverage

On top of routine hearing exams, most plans include a lower copay for high-quality hearing aids from TruHearing.™ If you're enrolled in a plan that offers this benefit, additional information can be found below.

Protect your hearing with top-notch care and cost-saving perks:

- **Save with discounts on hearing devices.** They typically cost between $2,720 to $3,250 but we offer affordable copays of $999 or less. See your Summary of Benefits for discounted rate.
- **Personalized care** — meet with a local provider for your exam plus three follow-up visits for fittings and adjustments.
- **State-of-the-art technology** — experience the latest advances in hearing aids.
- **Free first year follow-up provider visits.**
- **Risk-free 60-day trial period.**
- **Three-year extended warranty.**
- **80 free batteries per device.**

To learn more, visit TruHearing.com or call 1-844-208-2624
8 a.m. – 8 p.m., Monday – Friday (TTY 711).

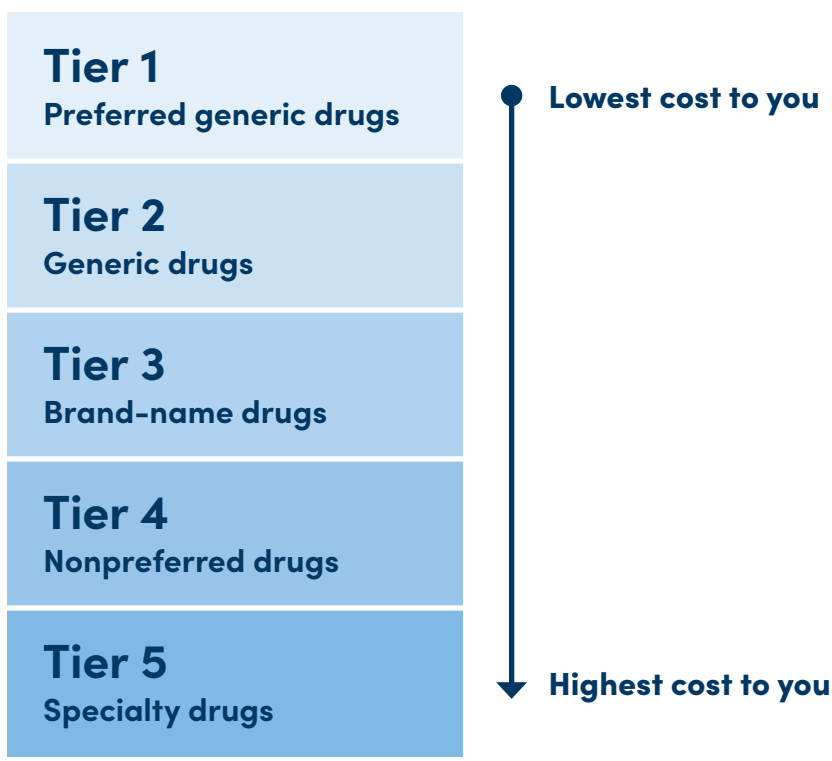
Prescription drug coverage

Understand your prescription drug coverage.

When it comes to your medications, Highmark makes sure you have access to safe, cost-effective drugs through the Medicare Part D prescription drug benefit. The list of drugs that are covered is called a formulary, which includes both generic and brand-name medications.

Prescription drug tiers

The drugs in the formulary are divided into five tiers. To save money, your best option is to choose drugs from Tier 1 and Tier 2 when possible.



The three stages of Medicare prescription drug coverage.

1

Stage 1 Deductible

You pay a set amount before your plan kicks in.
If you have a $0 deductible, you skip this and start in Stage 2.

2

Stage 2 Initial coverage

You pay the regular tier copay or coinsurance for your prescriptions. Once the total cost of your medications reaches $2,000, you move to Stage 3.

3

Stage 3 Catastrophic coverage

You have a $0 cost share for covered Part D drugs and vaccinations, including insulin products.

Save money on prescriptions with mail-order pharmacy.

If you take medications regularly, Express Scripts can make life simpler with prescriptions delivered right to your door. With Express Scripts, you get:

- Free standard shipping.
- Tier 1 generic drugs for as low as $0.
- Up to a 100-day supply of Tier 1 and Tier 2 drugs with just one, two, or two-and-a-half copays.
- Up to a 90-day supply of Tier 3 and Tier 4 drugs with just one, two, or two-and-a-half copays.

To find out if your drug is in the formulary, visit **medicare.highmark.com**. You can search for a specific drug or a category of drugs. If your drug isn't in the formulary, talk with your doctor. They can help you find an alternative.

How to fill prescriptions

You have four ways to fill your prescriptions with Express Scripts:

1. Ask your doctor to send your prescriptions electronically to the Express Scripts Pharmacy.
2. Call Member Service at the number on the back of your member ID card.
3. Go to express-scripts.com and register for an account.
4. Visit medicare.highmark.com to print an order form and mail it in.

If you have questions, call 1-800-329-2792 (TTY 711).

Medication therapy management program

A medication therapy management (MTM) program is a covered service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs.

You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected.

You may qualify for this program if you:

- Have **at least three** of the following chronic conditions: Alzheimer's disease, bone disease/arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis), chronic congestive heart failure (CHF), diabetes, dyslipidemia, end-stage renal disease (ESRD), human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), hypertension, mental health (including depression, schizophrenia, bipolar disorder, and chronic/disabling mental health conditions) or respiratory disease (including asthma, chronic obstructive pulmonary disease (COPD), and chronic lung disorders).
- Are taking **at least eight** Part D maintenance medications.
- Have annual costs of **at least $1,623** for covered Part D medications.

Extra help from Medicare

You may qualify for assistance paying for your prescription drugs through Medicare's low-income subsidy program. If you get this help, your monthly plan premium will be lowered by the amount of your subsidy.

To find out more about this program,
call 1-800-MEDICARE (633-4227) 24 hours a day, seven days a week. TTY users should call 1-877-586-2048.

Wellness perks

Highmark wellness rewards and personalized wellness plan.

As a Highmark Medicare Advantage member, you'll receive a Personalized Wellness Plan up to twice a year. It includes a checklist of preventive tests, screenings, and healthy activities to complete throughout the year.

Plus, you're automatically enrolled in the Highmark Wellness Rewards Program. As you check off activities on your Personalized Wellness Plan, you'll earn a reward for any eligible activities. We'll send you details about the Wellness Reward Card features at the beginning of the year.

Highmark House Call

Get a general wellness exam, suggestions for screenings or other tests, and a medicine review. To schedule a no-cost in-home or virtual house call, call us at **1-855-215-9239** (TTY 711) or visit **medicare.highmark.com**. Click **Learn**, enter your ZIP code, then click Plan **Perks and Services** and then **Highmark House Call.**

FitOn Health fitness benefits.

FitOn gives you access to over 13,000 gyms and studios across the country, plus a large library of digital fitness classes. This fitness benefit is available at no cost, so you can stay active on your own terms.

Your membership comes with:

- **Wellness classes to help you build healthy habits.**
- **Meal planning resources with 500+ exclusive recipes.**
- **Educational courses for managing chronic conditions.**
- **Expert advice on topics like nutrition, weight loss, sleep, mindfulness, stress relief, and more.**

FitOn also offers more flexibility. Beyond large chain gyms, you can also visit smaller gyms and private studios. So no matter where you are or how you exercise, you always have options nearby.

To learn more, visit **Fitonhealth.com**.

Chiropractic care

Our plans give you access to routine chiropractic visits through a participating provider. Check the Summary of Benefits for details on the number of covered visits per year.

Acupuncture and massage therapy

If you're enrolled in a plan that offers this benefit, you can see any acupuncture or massage therapy provider you choose and get reimbursed for the cost of your covered services up to your annual allowance.

Star Ratings

IMPORTANT INFORMATION:

2024 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Highmark Blue Cross Blue Shield or Highmark Blue Shield - H5526

For 2024, Highmark Blue Cross Blue Shield or Highmark Blue Shield - H5526 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★☆
Health Services Rating:	★★★★☆
Drug Services Rating:	★★★★☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online
Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions? Call us at: 1-800-329-2792 (TTY 711)

We're available:

October 1 – March 31	7 days a week, 8 a.m. to 8 p.m.
April 1 – September 30	Monday – Friday, 8 a.m. to 8 p.m.

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield or Highmark Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. Highmark Blue Cross Blue Shield or Highmark Blue Shield are Medicare Advantage HMO, PPO, and/or Part D plans with a Medicare contract. Enrollment in these plans depends on contract renewal.

Product information/ Summary of Benefits

CASHIC - Schalmont CSD Medicare PPO Plan DNU7 Grp 10728335

	2025 Forever Blue 799 (PPO) Plan DNU7 TRx (OOA) Summary of Benefits	
	In-Network	**Out-of-Network**
Important Information		
Premium and Other Important Information	If you currently pay a premium for your coverage, please reach out to your Group Benefit Administrator to find out your cost. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. For more information about Part B premiums based on income, visit www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	
Plan Deductible	This plan does not have a medical deductible	
Combined In and Out-of-Network Out-of-Pocket Maximum (does not include Part D Drugs)	$3,000	
Covered Medical and Hospital Benefits		
Note:	Services with a 1 may require prior authorization.	
Inpatient Hospital Care[1] (includes Substance Abuse and Rehabilitation Services) Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	You pay: $0 per stay.	You pay: $0 per stay.
Outpatient Hospital/Ambulatory Surgery Center[1]	You pay: $50 Copay Outpatient Hospital You pay: $50 Copay Ambulatory Surgery Center	You pay: $50 Copay Outpatient Hospital You pay: $50 Copay Ambulatory Surgery Center

Doctor Office Visits Office visit copays do not apply to the annual deductible if applicable	You pay: $20 Copay Primary Care Physician visit You pay: $20 Copay Specialist visit	You pay: $20 Copay Primary Care Physician visit You pay: $20 Copay Specialist visit
Preventive Services	You pay: $0 copay Our plan covers many preventive services, including: Abdominal Aortic Aneurysm Screening, Alcohol misuse counseling, Bone Mass Measurement, Breast cancer screening (mammogram), Cardiovascular disease (behavioral therapy), Cardiovascular screenings, Cervical and Vaginal Cancer Screening, Colorectal Cancer Screening (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy), Depression screening, Diabetes Screening, HIV screening, Medical nutrition therapy services, Obesity screening and counseling, Prostate cancer screenings (PSA), Sexually transmitted infections screening and counseling, Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease), Vaccine, including Flu shots, Hepatitis B shots, Pneumococcal shots, "Welcome to Medicare" preventive visit (one-time), Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. If the doctor provides you additional services, separate doctor office visit cost sharing may apply.	
Emergency Care You may go to any emergency room if you reasonably believe you need emergency care.	You pay $50 Copay for each emergency room visit. Worldwide coverage for emergency and urgently needed care. If you are admitted to the hospital within 1-day(s) for the same condition, your copay is waived for the emergency room visit.	
Urgent Care This is **not** emergency care	You pay: $35 Copay	

Services with a 1 may require prior authorization

Diagnostic Tests, Lab, Radiology Services[1] Such as MRIs and CT Scans and X-rays	You pay: $0 Copay for lab/diagnostic services in a physician's office or independent lab. You pay: $0 Copay for lab/diagnostic services in an outpatient facility. You pay: $20 Copay for standard imaging services. You pay: $20 Copay for advanced imaging services. You pay: $20 Copay for therapeutic radiology services.	You pay: $0 Copay for lab/diagnostic services in a physician's office or independent lab. You pay: $0 Copay for lab/diagnostic services in an outpatient facility. You pay: $20 Copay for standard imaging services You pay: $20 Copay for advanced imaging services. You pay: $20 Copay for therapeutic radiology services.
Hearing Services Medicare covered Exam to diagnose and treat hearing and balance issues	You pay: $20 Copay	You pay: $20 Copay
Hearing Services Routine Exam up to 1 every year. Cost sharing is not applied to the Combined In and Out-of-Network Out-of-Pocket Maximum. Up to 1 every year	You pay: $45 Copay $699 Copay per aid per year for TruHearing Advanced. $999 Copay per aid per year for TruHearing Premium.	You pay: $45 Copay
Dental Services[1] Preventive dental services (such as cleaning) not covered Authorization rules may apply for Medicare-covered accidental dental services.	Medicare covered dental benefits you pay: $0 Copay.	Medicare covered dental benefits you pay: $20 Copay.
Dental Services[1]	$200 Dental Annual Allowance	

Services with a 1 may require prior authorization

Vision Medicare covered Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	You pay: $20 Copay You pay: $0 copay for annual screening for diabetic retinopathy (for people with diabetes) You pay: $0 copay for eyeglass or contact lenses after cataract surgery with a participating Davis Vision provider.	You pay: $20 Copay You pay: $0 copay for annual screening for diabetic retinopathy (for people with diabetes) You pay: $0 Copay for eyeglass or contact lenses after cataract surgery for all other providers
Routine Vision A Davis Vision provider must be used to be considered in-network	Routine eye exam (for up to 1 every year) you pay: $15 Copay	You pay: 20% Coinsurance for routine eye exams.
	$200 Annual allowance (lenses and frames) offered through Davis Vision.	
Mental Health Care[1] Inpatient visit: Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital . Office visit copays do not apply to the annual deductible.	Inpatient stay you pay: $0 per stay Outpatient individual/group therapy visit for other mental health care services you pay: $40 Copay Outpatient individual therapy visit with a psychiatrist you pay: $20 Copay	Inpatient stay you pay: $0 per stay Outpatient individual/group therapy visit for other mental health care services you pay: $40 Copay Outpatient individual therapy visit with a psychiatrist you pay: $20 Copay
Skilled Nursing Facility (SNF)[1] Medicare-certified skilled nursing facility	You pay: $0 Copay per admission for days 1-100. No prior hospital stay is required.	You pay: $0 Copay per admission for days 1-100. No prior hospital stay is required.
Physical Therapy[1]	You pay: $20 Copay for Medicare-covered Physical Therapy visits.	You pay: $20 Copay for Medicare-covered Physical Therapy visits.
Ambulance Services[1] Medically necessary ambulance services	You pay: $50 Copay	Emergency - You pay: $50 Copay

Services with a 1 may require prior authorization

Transportation (Routine)[1] Combined 24 one-way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.	Not Covered	Not Covered for out-of-network transportation services.
Part B Drugs[1] Drugs covered under Medicare Part B. See Section 1 for more Information on Medicare Part B Drugs. Part B covers Immunosuppressive drugs, Oral chemotherapy drugs, Physician administered injectables, Nebulizer drugs and other Part B drugs	You pay: 0% Coinsurance	You pay: 0% Coinsurance
Acupuncture Medicare-covered Acupuncture visits up to 12 visits in 90 days for chronic low back pain	You pay: $20 Copay for Medicare-covered Acupuncture visits.	You pay: $20 Copay for Medicare-covered Acupuncture visits.
Acupuncture & Massage Therapy	$500 allowance combined with Massage Therapy	
Chiropractic Care[1] Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part)	You pay: $20 Copay	You pay: $20 Copay
Chiropractic Care Routine Chiropractic visits up to 12 visits per year. (Visit limit combined In-Network and Out-of Network)	You pay: $20 Copay	You pay: $20 Copay
Supplies, equipment and devices[1]	Durable Medical Equipment - You pay: $0 for compression stockings; $0 Copay for all other items. Prosthetics - You pay: $0 for diabetic shoes/inserts: $0 Copay for all other items. Diabetic supplies - You pay: $0 Copay	Durable Medical Equipment - You pay: $0 Copay. Prosthetics - You pay: $0 Copay. Diabetic supplies - You pay: $0 Copay

Services with a 1 may require prior authorization

Foot Care *(podiatry services)* Medicare covered exam -Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	You pay: $20 Copay	You pay: $20 Copay
Foot Care *(podiatry services)* Routine visits up to 3 visits per year. (Visit limit combined In-Network and Out-of Network)	You pay: $20 Copay	You pay: $20 Copay
Home Health Care[1]	You pay: $0 Copay	You pay: $0 Copay
Outpatient Rehabilitation[1] **Cardiac Rehabilitation** **Occupational Therapy, Physical Therapy, Speech and Language Therapy**	You pay: $20 Copay for Cardiac (heart) Rehabilitation services. You pay: $20 Copay for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.	You pay: $20 Copay for Cardiac (heart) Rehabilitation services. You pay: $20 Copay for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.
Over the Counter Drug Allowance	Not Covered	
Renal Dialysis Services to Treat Kidney Disease	You pay: $0 Copay	Inside service area you pay: 20% Coinsurance for non-participating providers. Outside service area $0 Copay for non-participating providers.
Wellness/Education and Other Supplemental Benefits & Services	The plan covers the following supplemental education/wellness programs: Nationwide Fitness Network Membership/Fitness Classes	The plan covers the following supplemental education/wellness programs: Nationwide Fitness Network Membership/Fitness Classes
Hospice	You pay: $0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	

Services with a 1 may require prior authorization

Meals After Inpatient Discharge (1 meal per day up to 7 days upon Discharge from an Inpatient Hospital or SNF Stay. Must be activated within 30 days of discharge)	Covered

Services with a 1 may require prior authorization

Part D Prescription Drug Benefits

DRUG

You pay the following until you reach the True Out of Pocket (TrOOP) costs threshold of $2,000.

Deductible - $0

Initial Coverage

Preferred Retail Pharmacy

Tier	31 Day Supply	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
Tier 1 (Preferred Generic Drugs)	$0 Copay	$0 Copay
Tier 2 (Generic Drugs)	$10 Copay	$30 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$25 Copay	$75 Copay
Tier 4 (Non-Preferred Drugs)	$40 Copay	$120 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	$40 Copay	Not Available

Network Retail Pharmacy

Tier	31 Day Supply	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
Tier 1 (Preferred Generic Drugs)	$5 Copay	$15 Copay
Tier 2 (Generic Drugs)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$30 Copay	$90 Copay
Tier 4 (Non-Preferred Drugs)	$45 Copay	$135 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	$45 Copay	Not Available

Mail Order (Express Scripts)

Tier	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
Tier 1 (Preferred Generic Drugs)	$0 Copay
Tier 2 (Generic Drugs)	$20 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$50 Copay
Tier 4 (Non-Preferred Drugs)	$80 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	$40 Copay for a 31 day limit supply

Mail Order (All other Mail Order Pharmacies)

Tier	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
Tier 1 (Preferred Generic Drugs)	$10 Copay
Tier 2 (Generic Drugs)	$30 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$60 Copay
Tier 4 (Non-Preferred Drugs)	$90 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	$45 Copay for a 31 day limit supply

Catastrophic Coverage	After reaching the True Out of Pocket (TrOOP) costs, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.
Formulary	Fundamental

Important Message If you have prescription cost sharing more than $35/month - What You Pay for Insulin – The maximum copayment for a one-month supply of covered insulin products is $35, no matter what cost-sharing tier it is on or if you have not met your Rx deductible (if applicable).

For questions about this plan's benefits or costs, please contact Forever Blue. Call 1-866-456-7739, (TTY users call 711), Monday through Friday, between 8 a.m. and 4:30 p.m. ET. Please have Reference Code 25FB0DNU7 10728335 ready when you call.

HIGHMARK

Because Life.™

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Highmark Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal. Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit. Davis Vision, a subsidiary of Versant Health, is a separate company. Express Scripts is an independent company that administers the pharmacy benefit for your health plan. Other Pharmacies/ Physicians/Providers are available in our network. Out-of-network/non-contracted providers are under no obligation to treat Plan members except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY:711)

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

我们免费提供口译服务，为您解答有关我们健康计划或药物 计划的任何疑问。如需口译服务，只需拨打您所在州相应的 电话 号 码即可。说中文的工作人员可为您提供帮助。此项服务免 费。

Enrollment materials

MEDICARE ADVANTAGE GROUP ENROLLMENT APPLICATION

HIGHMARK®

If you have any questions about our plans, need help filling out this application, or need information in another language or format (Braille), please call 1-855-215-9239 (TTY 711).

Monday – Friday, 8 a.m. to 4:30 p.m.

Mailing Address: P.O. Box 15013, Albany, NY 12212 • Physical Address: 40 Century Hill Drive • Latham, NY 12110

PART 1 PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN

Employer or Union Name CASHIC-Schalmont CSD **Location** _____

Member plan selection:

☒	10728335 Forever Blue 799 (PPO) Plan DNU7 TRx	☐	_____
☐	_____	☐	_____
☐	_____	☐	_____
☐	_____	☐	_____

Effective Date _____ **Member bill level selection:** ☐ **Group bill** ☐ **Member bill**

PART 2 PLEASE TELL US ABOUT YOURSELF

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (MM/DD/YYYY) _____ Sex ☐ M ☐ F

Email Address _____

PERMANENT RESIDENCE STREET ADDRESS: **(Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)**

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

Home Phone Number ( ) _____ Alternative Phone Number ( ) _____
area code area code

MAILING ADDRESS (ONLY IF DIFFERENT FROM PERMANENT ADDRESS):

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

PART 3 MEDICAL ELIGIBILITY INFORMATION

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number

_____

Entitled to:

Hospital (Part A) Effective Date _____ / _____ / _____

Medical (Part B) Effective Date _____ / _____ / _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

EGHP_24_6817_C ENR-476 (9-24)

PART 4 **PLEASE LIST A PRIMARY CARE DOCTOR FROM THE PROVIDER DIRECTORY**

Doctor's Last Name _____ First Name _____

Current Patient? ☐ Yes ☐ No

PART 5 **PLEASE READ AND ANSWER THESE QUESTIONS**

1. **Are you the retiree?** ☐ Yes ☐ No

   If YES, retirement date (MM/DD/YYYY) _____

   If NO, name of retiree _____

2. **Are you the spouse of the retiree?** ☐ Yes ☐ No

3. **Are you covering a spouse or dependents under this employer or union plan?** ☐ Yes ☐ No

   If YES, name of spouse _____

   Name of dependents _____

4. **Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Highmark Blue Shield HMO or PPO?** ☐ Yes ☐ No

   If YES, please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage _____

   ID# for this coverage _____ Group# for this coverage _____

5. **Are you a resident in a long-term care facility such as a nursing home?** ☐ Yes ☐ No

   If YES, please list the institution's name, address, phone number, and date of admission.

   Name _____ Street _____ Suite# _____

   City _____ State _____ ZIP Code _____

   Phone ( ) _____ County _____ Date of Admission _____
   area code (MM/DD/YYYY)

6. **Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No

   If YES, please provide your Medicaid number _____

7. **Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits?** ☐ Yes ☐ No

   If YES, what kind of insurance do you have? _____

   What is the name of your insurance? _____

8. **Do you or does your spouse work?** ☐ Yes ☐ No

PART 6 **PLEASE READ AND SIGN ON PAGE 4**

By completing this enrollment application, I agree to the following:

Highmark Blue Shield HMO or PPO are Medicare Advantage Plans and have a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (example: annual enrollment period from October 15 – December 7), or under certain special circumstances.

Highmark Blue Shield HMO or PPO serve a specific service area. If I move out of the area that Highmark Blue Shield HMO or PPO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Highmark Blue Shield HMO or PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Highmark Blue Shield HMO or PPO once I receive it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that, beginning on the date Highmark Blue Shield HMO or PPO coverage begins, I must get all of my health care from Highmark Blue Shield, except for emergency or urgently needed services or out-of-area dialysis services. I understand that, beginning on the date Highmark Blue Shield HMO or PPO coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Highmark Blue Shield HMO or PPO provides refunds for all covered benefits, even if I get services out of network. Services authorized by Highmark Blue Shield and other services contained in my Highmark Blue Shield HMO and PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HIGHMARK BLUE SHIELD WILL PAY FOR THE SERVICES**.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Highmark Blue Shield, the employee may be paid based on my enrollment in Highmark Blue Shield HMO or PPO.

Release of Information:

By joining this Medicare health plan, I acknowledge that Highmark Blue Shield will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Highmark Blue Shield will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

PART 6 **ENROLLEE AUTHORIZATION — SIGNATURE**

Enrollee Authorization

_____ _____

Signature **Today's Date**

If you are an authorized representative, you must sign above and provide the following information:

Last Name _____ First Name _____ Middle Initial _____

Street/Apartment# _____

City _____ State _____ County _____ Zip Code _____

Home Phone Number ( ) _____ Relationship to Enrollee _____
area code

Please include a copy of your Power of Attorney paperwork.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a or Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban
- ❑ **I choose not to answer.**

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- ❑ Chinese
- ❑ Japanese
- ❑ Other Asian
- ❑ Vietnamese
- ❑ Asian Indian
- ❑ Filipino
- ❑ Korean
- ❑ Other Pacific Islander
- ❑ White
- ❑ Black or African American
- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Somoan
- ❑ **I choose not to answer**

What is your gender? Select One.

- ❑ Woman ❑ Man ❑ Non-binary ❑ I use a different term_____
- ❑ **I choose not to answer**

Which of the following best represents how you think of yourself? Select One.

- ❑ Lesbian or gay ❑ Straight, that is not gay or lesbian ❑ Bisexual
- ❑ I use a different term_____ ❑ I don't know ❑ **I choose not to answer**

Please check one of the boxes below if you want us to contact you about receiving information in a language other than English or in an accessible format:

☐ I would like to receive my materials in a language other than English

☐ I would like to receive my materials in an accessible format (Braille, Large Print, Data CD, Audio CD, etc.)

Please contact Highmark at 1-800-329-2792 if you need information in an accessible format or language other than English. TTY users should call 711. Our office hours are:

October 1 – March 31	**8 a.m. to 8 p.m., 7 days a week**
April 1 – September 30	**8 a.m. to 5 p.m., Monday – Friday**

For individuals helping enrollee with completing this form only

Name: _____

National Producer Number (Agents/Brokers only): _____

Relationship to Enrollee: _____

Effective Date of Coverage:_____

Date Received:_____

Signature: _____

HIGHMARK.
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

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

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

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

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

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY: 711)

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call the number provided for your state of residence. Someone who speaks English can help you. This is a free service.

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

我们免费提供口译服务，为您解答有关我们健康计划或药物计划的任何疑问。如需口译服务，只需拨打您所在州相应的电话号码即可。说中文的工作人员可为您提供帮助。此项服务免费。

我們免費提供口譯服務，爲您解答有關我們健康計畫或藥物計畫的任何疑問。若要獲得口譯服務，只需撥打您所在州的電話號碼即可。講漢語的工作人員可爲您提供協助。此項服務免費。

Mayroon kaming mga libreng serbisyo ng interpreter para sagutin ang anumang tanong na posibleng mayroon ka tungkol sa aming planong pangkalusugan o plano sa gamot. Para kumuha ng interpreter, tawagan lang ang numerong ibinigay para sa estadong tinitirhan mo. May taong nagsasalita ng Tagalog na makakatulong sa iyo. Isa itong libreng serbisyo.

Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous vous posez sur notre régime d'assurance maladie ou d'assurance médicaments. Pour obtenir les services d'un interprète, il vous suffit d'appeler le numéro correspondant à votre État de résidence. Une personne parlant français pourra vous aider. Ce service est gratuit.

Chúng tôi cung cấp dịch vụ thông dịch miễn phí để giải đáp mọi thắc mắc của quý vị về chương trình sức khỏe hoặc thuốc của chúng tôi. Để có thông dịch viên, chỉ cần gọi số được cung cấp cho tiểu bang cư trú của quý vị. Ai đó nói Tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

Wir verfügen über kostenlose Dolmetschdienste, damit Sie alle eventuellen Fragen zu unserer Krankenversicherung oder zur Medikamenten-Zusatzversicherung klären können. Rufen Sie hierzu einfach die Nummer für den Bundesstaat an, in dem Sie Ihren Wohnsitz haben. Jemand, der Deutsch spricht, wird Ihnen behilflich sein. Dies ist ein kostenloser Service.

لدينا خدمات ترجمة فورية مجانية للإجابة عن أي أسئلة قد تراودك حول خطتنا الصحية أو الدوائية. للحصول على مترجم فوري، فقط اتصل بالرقم المقدم للولاية التي تقيم فيها. ويمكن لشخص يتحدث العربية مساعدتك. هذه خدمة مجانية.

건강 또는 약물 플랜에 대한 귀하의 질문에 답변해 드릴 수 있는 무료 통역 서비스를 제공해 드립니다. 통역사를 구하려면 거주하시는 주의 전화 번호로 문의하십시오. 한국어을(를) 말할 수 있는 직원이 도와드릴 수 있습니다. 이 서비스는 무료로 제공합니다.

Мы предоставляем бесплатные услуги устного перевода, чтобы помочь вам получить ответы на любые вопросы, которые могут у вас возникнуть в отношении нашего медицинского плана или плана лекарственных препаратов. Чтобы заказать услуги переводчика, просто позвоните по номеру, указанному для штата, в котором вы проживаете. Один из наших переводчиков, специализацией которого является русский язык, поможет вам. Эта услуга предоставляется бесплатно.

हमारे पास हमारी स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए मुफ्त दुभाषिया सेवाएँ हैं। एक दुभाषिया प्राप्त करने के लिए, बस अपने निवास स्थान की स्टेट के लिए दिए गए नंबर पर कॉल करें। हिंदी बोलने वाला कोई व्यक्ति आपकी सहायता कर सकता है। यह एक निःशुल्क सेवा है।

Disponiamo di servizi di interpretariato gratuiti per rispondere a ogni sua domanda riguardo al suo piano sanitario o farmaceutico. Per ottenere l'assistenza di un interprete, chiami il numero fornito per il suo stato di residenza. Qualcuno che parla italiano la aiuterà. Il servizio è gratuito.

Temos serviços de interpretação gratuitos para esclarecer suas dúvidas sobre nosso plano de saúde ou de medicamentos. Para contar com um intérprete, ligue para o número fornecido para o seu estado de residência. Alguém que fale Português pode ajudar você. Este é um serviço gratuito.

Nou gen sèvis entèpretasyon gratis pou reponn ak nenpòt kesyon ou ta ka genyen sou plan asirans sante oswa medikaman nou an. Pou jwenn yon entèprèt ede w, senpleman rele nimewo ki koresponn ak Eta kote w rete a. Yon moun ki pale Kreyòl Ayisyenap ede w. Sèvis sa a gratis.

Dysponujemy darmowymi usługami tłumaczeniowymi, dzięki którym może Pan/Pani uzyskać odpowiedzi na pytania dotyczące naszego planu zdrowia lub leków. Aby uzyskać pomoc tłumacza, wystarczy zadzwonić pod numer podany dla stanu, w którym Pan/Pani mieszka. Ktoś, kto zna język polsku, może Panu/Pani pomóc. Ta usługa jest darmowa.

当院では、無料の通訳サービスを用意し、治療や投薬計画に関するご質問にお答えしています。通訳を手配したい場合は、お住まいの州で指定された番号までお電話でご連絡ください。日本語話せる者が対応をお手伝いします。サービスは無料でご利用いただけます。

MEDICARE ADVANTAGE GROUP ENROLLMENT APPLICATION

HIGHMARK®

If you have any questions about our plans, need help filling out this application, or need information in another language or format (Braille), please call 1-855-215-9239 (TTY 711).

Monday – Friday, 8 a.m. to 4:30 p.m.

Mailing Address: P.O. Box 15013, Albany, NY 12212 • Physical Address: 40 Century Hill Drive • Latham, NY 12110

PART 1 PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN

Employer or Union Name CASHIC-Schalmont CSD **Location** _____

Member plan selection:

☒	10728335 Forever Blue 799 (PPO) Plan DNU7 TRx	☐	_____
☐	_____	☐	_____
☐	_____	☐	_____
☐	_____	☐	_____

Effective Date _____ **Member bill level selection:** ☐ **Group bill** ☐ **Member bill**

PART 2 PLEASE TELL US ABOUT YOURSELF

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (MM/DD/YYYY) _____ Sex ☐ M ☐ F

Email Address _____

PERMANENT RESIDENCE STREET ADDRESS: **(Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)**

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

Home Phone Number ( ) _____ Alternative Phone Number ( ) _____
area code area code

MAILING ADDRESS (ONLY IF DIFFERENT FROM PERMANENT ADDRESS):

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

PART 3 MEDICAL ELIGIBILITY INFORMATION

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number

_____

Entitled to:

Hospital (Part A) Effective Date _____ / _____ / _____

Medical (Part B) Effective Date _____ / _____ / _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

EGHP_24_6817_C ENR-476 (9-24)

PART 4 **PLEASE LIST A PRIMARY CARE DOCTOR FROM THE PROVIDER DIRECTORY**

Doctor's Last Name _____ First Name _____

Current Patient? ☐ Yes ☐ No

PART 5 **PLEASE READ AND ANSWER THESE QUESTIONS**

1. **Are you the retiree?** ☐ Yes ☐ No

   If YES, retirement date (MM/DD/YYYY) _____

   If NO, name of retiree _____

2. **Are you the spouse of the retiree?** ☐ Yes ☐ No

3. **Are you covering a spouse or dependents under this employer or union plan?** ☐ Yes ☐ No

   If YES, name of spouse _____

   Name of dependents _____

4. **Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Highmark Blue Shield HMO or PPO?** ☐ Yes ☐ No

   If YES, please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage _____

   ID# for this coverage _____ Group# for this coverage _____

5. **Are you a resident in a long-term care facility such as a nursing home?** ☐ Yes ☐ No

   If YES, please list the institution's name, address, phone number, and date of admission.

   Name _____ Street _____ Suite# _____

   City _____ State _____ ZIP Code _____

   Phone ( ) _____ County _____ Date of Admission _____
   area code (MM/DD/YYYY)

6. **Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No

   If YES, please provide your Medicaid number _____

7. **Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits?** ☐ Yes ☐ No

   If YES, what kind of insurance do you have? _____

   What is the name of your insurance? _____

8. **Do you or does your spouse work?** ☐ Yes ☐ No

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Highmark Blue Shield HMO or PPO serve a specific service area. If I move out of the area that Highmark Blue Shield HMO or PPO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Highmark Blue Shield HMO or PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Highmark Blue Shield HMO or PPO once I receive it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that, beginning on the date Highmark Blue Shield HMO or PPO coverage begins, I must get all of my health care from Highmark Blue Shield, except for emergency or urgently needed services or out-of-area dialysis services. I understand that, beginning on the date Highmark Blue Shield HMO or PPO coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Highmark Blue Shield HMO or PPO provides refunds for all covered benefits, even if I get services out of network. Services authorized by Highmark Blue Shield and other services contained in my Highmark Blue Shield HMO and PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HIGHMARK BLUE SHIELD WILL PAY FOR THE SERVICES**.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Highmark Blue Shield, the employee may be paid based on my enrollment in Highmark Blue Shield HMO or PPO.

Release of Information:

By joining this Medicare health plan, I acknowledge that Highmark Blue Shield will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Highmark Blue Shield will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

PART 6 **ENROLLEE AUTHORIZATION — SIGNATURE**

Enrollee Authorization

_____ _____

Signature **Today's Date**

If you are an authorized representative, you must sign above and provide the following information:

Last Name _____ First Name _____ Middle Initial _____

Street/Apartment# _____

City _____ State _____ County _____ Zip Code _____

Home Phone Number ( ) _____ Relationship to Enrollee _____
area code

Please include a copy of your Power of Attorney paperwork.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a or Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban
- ❑ **I choose not to answer.**

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- ❑ Chinese
- ❑ Japanese
- ❑ Other Asian
- ❑ Vietnamese
- ❑ Asian Indian
- ❑ Filipino
- ❑ Korean
- ❑ Other Pacific Islander
- ❑ White
- ❑ Black or African American
- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Somoan
- ❑ **I choose not to answer**

What is your gender? Select One.

- ❑ Woman ❑ Man ❑ Non-binary ❑ I use a different term_____
- ❑ **I choose not to answer**

Which of the following best represents how you think of yourself? Select One.

- ❑ Lesbian or gay ❑ Straight, that is not gay or lesbian ❑ Bisexual
- ❑ I use a different term_____ ❑ I don't know ❑ **I choose not to answer**

Please check one of the boxes below if you want us to contact you about receiving information in a language other than English or in an accessible format:

☐ I would like to receive my materials in a language other than English

☐ I would like to receive my materials in an accessible format (Braille, Large Print, Data CD, Audio CD, etc.)

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For individuals helping enrollee with completing this form only

Name: _____

National Producer Number (Agents/Brokers only): _____

Relationship to Enrollee: _____

Effective Date of Coverage:_____

Date Received:_____

Signature: _____

HIGHMARK.
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

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  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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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.

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY: 711)

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call the number provided for your state of residence. Someone who speaks English can help you. This is a free service.

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

我们免费提供口译服务，为您解答有关我们健康计划或药物计划的任何疑问。如需口译服务，只需拨打您所在州相应的电话号码即可。说中文的工作人员可为您提供帮助。此项服务免费。

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Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous vous posez sur notre régime d'assurance maladie ou d'assurance médicaments. Pour obtenir les services d'un interprète, il vous suffit d'appeler le numéro correspondant à votre État de résidence. Une personne parlant français pourra vous aider. Ce service est gratuit.

Chúng tôi cung cấp dịch vụ thông dịch miễn phí để giải đáp mọi thắc mắc của quý vị về chương trình sức khỏe hoặc thuốc của chúng tôi. Để có thông dịch viên, chỉ cần gọi số được cung cấp cho tiểu bang cư trú của quý vị. Ai đó nói Tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

Wir verfügen über kostenlose Dolmetschdienste, damit Sie alle eventuellen Fragen zu unserer Krankenversicherung oder zur Medikamenten-Zusatzversicherung klären können. Rufen Sie hierzu einfach die Nummer für den Bundesstaat an, in dem Sie Ihren Wohnsitz haben. Jemand, der Deutsch spricht, wird Ihnen behilflich sein. Dies ist ein kostenloser Service.

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Мы предоставляем бесплатные услуги устного перевода, чтобы помочь вам получить ответы на любые вопросы, которые могут у вас возникнуть в отношении нашего медицинского плана или плана лекарственных препаратов. Чтобы заказать услуги переводчика, просто позвоните по номеру, указанному для штата, в котором вы проживаете. Один из наших переводчиков, специализацией которого является русский язык, поможет вам. Эта услуга предоставляется бесплатно.

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Disponiamo di servizi di interpretariato gratuiti per rispondere a ogni sua domanda riguardo al suo piano sanitario o farmaceutico. Per ottenere l'assistenza di un interprete, chiami il numero fornito per il suo stato di residenza. Qualcuno che parla italiano la aiuterà. Il servizio è gratuito.

Temos serviços de interpretação gratuitos para esclarecer suas dúvidas sobre nosso plano de saúde ou de medicamentos. Para contar com um intérprete, ligue para o número fornecido para o seu estado de residência. Alguém que fale Português pode ajudar você. Este é um serviço gratuito.

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Dysponujemy darmowymi usługami tłumaczeniowymi, dzięki którym może Pan/Pani uzyskać odpowiedzi na pytania dotyczące naszego planu zdrowia lub leków. Aby uzyskać pomoc tłumacza, wystarczy zadzwonić pod numer podany dla stanu, w którym Pan/Pani mieszka. Ktoś, kto zna język polsku, może Panu/Pani pomóc. Ta usługa jest darmowa.

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About our benefits and premiums

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help program, call one of the following:

- 1-800-MEDICARE (1-800-633-4227) (TTY 711), 24 hours a day, seven days a week.
- The Social Security office at 1-800-772-1213 (TTY 711), between 7 a.m. and 7 p.m., Monday through Friday.
- Your state Medicaid office.

About us

Highmark Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

FitOn Health is an independent company offering members a fitness benefit.

TruHearing is a registered trademark of TruHearing, Inc., a separate company.

Care at Home℠ is a program for Highmark Blue Shield members and is administered by Landmark, a separate company.

Well360 Virtual Health is offered by your health plan and powered by Amwell. Amwell is an independent company that provides telemedicine services and does not provide Blue Cross and/or Blue Shield products or services. Amwell is solely responsible for their telemedicine services.

Davis Vision is an independent company that provides the network and administers vision benefits for Highmark members.

Express Scripts® is a separate company.

Every year, Medicare evaluates plans based on a 5-star rating system.

Other Pharmacies/Physicians/Providers are available in our network.

Out-of-network/non-contracted providers are under no obligation to treat Plan members except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

To join a Medicare Advantage plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in New York State:

Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, Washington.

The Visitor/Travel Program will include Blue Medicare Advantage PPO network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 48 states and 2 territories: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and West Virginia. For some of the states listed, MA PPO networks are only available in portions of the state.

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Connect with us.

We’re on most of your favorite social media sites, so contact us there if it’s easier for you. You can say hi, ask questions, or give feedback.
Find us here:

We’ve got your back.

For coverage questions, call the number on the back of your member ID card or talk with your plan administrator.