Medicare Advantage Employer Group
Enrollment Kit 2027

With Highmark, you're getting so much more than just Medicare.

HIGHMARK.

Because Life.™

Over 80 years of security and stability.

Highmark Blue Cross Blue Shield is part of a network that's been providing peace of mind for the better part of a century. And with one in three* Americans covered by that same network today, when you're with Highmark, you're in good company.

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Questions about how your Medicare Advantage plan works?

Call us at 1-866-456-7739 (TTY call 711),
Monday – Friday, 8 a.m. – 4:30 p.m.

* According to the Blue Cross Blue Shield Association, an association of independent Blue Cross and/or Blue Shield plans; bcbs.com.

Senior Blue HMO

Summary of Benefits

January 1, 2027 to December 31, 2027

Thank you for your interest in **Senior Blue HMO**. Our plan is offered by Highmark Blue Cross Blue Shield, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or every limitation or exclusion. You can request an Evidence of Coverage that contains a full list of benefits by calling us at **1-866-456-7739** (TTY call 711), Monday – Friday, 8 a.m. – 4:30 p.m. ET.

New York State Employees (WNY) Medicare HMO Plan E Grp 10717145

	2027 Senior Blue 699 (HMO) Plan E Summary of Benefits
	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	
Notes:	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
Outpatient Hospital/ Ambulatory Surgery Center[1]	You pay: $75 copay Outpatient Hospital You pay: $75 copay Ambulatory Surgery Center
Doctor Office Visits Office visit copays do not apply to the annual deductible if applicable	You pay: $10 copay Primary Care Physician Visit You pay: $30 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: $65 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.

*Services with a 1 may require prior authorization

Urgent Care This is **not** emergency care	You pay: $35 copay
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: $30 copay for standard imaging services You pay: $30 copay for advanced imaging services. You pay: $30 copay for therapeutic radiology services.
Hearing Services Medicare covered exam to diagnose and treat hearing and balance issues	You pay: $30 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.	You pay: $45 copay $699 copay per aid per year for TruHearing Advanced. $999 copay per aid per year for TruHearing Premium.
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.
Dental Services[1]	$200 Annual Dental Allowance.
Vision Medicare covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	You pay: $30 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 particpating Davis Vision provider.
Routine Vision	Routine eye exam (for up to 1 every year) you pay: $0 copay Eyewear Limited to one pair of eyeglass frames with eyeglass lenses or contact lenses every calendar year. Davis Vision Fashion Collection eyeglass frames, standard eyeglass lenses and standard contact lenses are covered in full. You pay $25 copay for Designer Davis Collection Frames. You pay $40 copay for Premier Davis Collection Frames. A $200 copay benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses.
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: $40 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.
Physical Therapy[1]	You pay: $20 copay for Medicare-covered Physical Therapy visits.

*Services with a 1 may require prior authorization

Ambulance Services[1] Medically necessary ambulance services	You pay: $100 copay
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
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 will not pay more than $35 for insulin.
Acupuncture Medicare-covered Acupuncture visits up to 12 visits in 90 days for chronic low back pain.	You pay: $30 copay for Medicare-covered Acupuncture visits.
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
Chiropractic Care Routine Chiropractic visits up to visits per year.	Not Covered
Supplies, equipment and devices[1]	Durable Medical Equipment - You pay: $0 for compression stockings; 20% coinsurance for all other items. Prosthetics - You pay: $0 for diabetic shoes/inserts: 20% coinsurance for all other items. Diabetic supplies - You pay: $0 copay
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: $30 copay
Foot Care (podiatry services) Routine visit up to 3 visits per year.	You pay: $30 copay
Home Health Care[1]	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.
Over the Counter Drug Allowance	Not Covered
Renal Dialysis Services To Treat Kidney Disease	You pay: $0 copay
Wellness/Education and Other Supplemental Benefits & Services	The plan covers the following supplemental education/wellness programs: Nationwide Fitness Network Membership/Fitness Classes

*Services with a 1 may require prior authorization

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.
Meals After Inpatient Hospital Discharge (2 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

DRUG	Part D Prescription Drug Benefits				
	You pay the following until you reach the True Out of Pocket (TrOOP) costs threshold of $2,400. Deductible - $0				
	Formulary Type	Performance			
	Initial Coverage	**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)	$0 copay	$0 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)	$50 copay	$150 copay
			Tier 5 (Specialty Drugs consist of both Generic and Brand)	$50 copay	Not Available
		Mail Order	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)	$30 copay	
			Tier 3 (Preferred Brand Drugs and Generics)	$60 copay	
			Tier 4 (Non-Preferred Drugs)	$100 copay	
			Tier 5 (Specialty Drugs consist of both Generic and Brand)	$50 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.			
	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 Senior 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 27SB0E10717145 ready when you call.

You have choices when it comes to your health care.

As a Medicare beneficiary, you can choose from different Medicare options like the Original (fee-for-service) Medicare plan or a Highmark Medicare Advantage plan. You may have other options too. But no matter what you decide, you're still in the Medicare program.

More about Original Medicare:

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 may call 1-877-486-2048. You can also compare your Highmark plan and Original Medicare plans by using this Summary of Benefits and visiting **medicare.gov**.

Already have Medicare Supplement insurance? Here's what to do next.

If you have a Medicare Supplement policy and enroll in a Medicare Advantage plan, it's important to contact your Medicare Supplement carrier. Let them know about your new plan and ask about any changes to your coverage.

Have questions about drugs covered under Medicare Part B?

Your health plan is here to help. Just give us a call at **1-866-456-7739** (TTY call 711), Monday – Friday, 8 a.m. – 4:30 p.m.

What type of drugs may be covered under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs:

- **Some antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin Alfa or Epogen®):** Injectable drugs for end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and anemia.
- **Hemophilia clotting factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable drugs:** Most injectable drugs administered during a physician's visit.
- **Immunosuppressive drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some oral cancer drugs:** If the same drug is available in injectable form.
- **Oral anti-nausea drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and infusion drugs:** Drugs provided through durable medical equipment (DME).
- **Pre-exposure prophylaxis (PrEP) drugs:** FDA-approved drugs that help prevent HIV.

Medicare Advantage Plan Types

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. Please see the **Summary of Benefits** included in this document to determine which plan type you are offered.

HMO plans

With our **HMO** (Health Maintenance Organization) plan, you usually have lower out-of-pocket costs, but you must receive care from doctors and hospitals within the plan's network.

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.

PDP (Prescription Drug Plan)

With our PDP plan, you have coverage for generic and brand-name drugs allowed by Medicare. Prescriptions can be filled at more than 58,000 participating retail pharmacies or through the home delivery service.

What happens if I go to a doctor who's not in our network?

You can go to doctors, specialists, or hospitals in or out of network. Just keep in mind that out-of-network care may cost more, and certain rules may apply before you receive services.

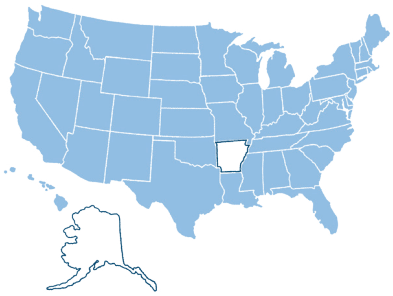
Out-of-network or non-contracted providers are under no obligation to treat Medicare Advantage members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a preservice organization determination before you receive the service.

For a full list of cost sharing that applies to out-of-network services, please see the Summary of Benefits included in this document. For more information, please call us at **1-866-456-7739** (TTY call 711), Monday – Friday, 8 a.m. – 4:30 p.m.

When you're in the U.S.

For care 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 48 states*, one territory, and one district:



AL, 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, WI, WV, WY.

* For some of the states listed, MA PPO networks are only available in portions of the state.

To find out if a doctor participates in the Medicare Advantage PPO network-sharing program, call us at **1-866-456-7739** (TTY call 711), Monday – Friday, 8 a.m. – 4:30 p.m., 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 excluding your share of the cost.

Get help with your Medicare Advantage plan.

If you need to find an in-network provider or facility for medical, dental, or pharmacy, you can always use our searchable online directory. First, visit **medicare.highmark.com/home** and click on the type of care you're looking for at the bottom of the page.

From there, follow the steps below based on the type of care you selected.

Medical

Select **Find a Provider** at the bottom of the page. Then, select your plan and enter your **city** and **state** or **ZIP** code. Type the provider or facility you're looking for and hit **Enter**.

Dental

Select **Find a Dentist** at the bottom of the page, then enter your **city** and **state** or **ZIP** code. You can then search by provider name, practice, or dentist type.

Pharmacy

Select **Find a Pharmacy** at the bottom of the page. Then, click **Medicare Preferred Performance Network** or **National Performance Medicare Network**. Enter your **ZIP** code to see the list of pharmacies in your area.



Whether you need Medicare questions answered, your preventive care services explained, or help finding an in-network provider, Highmark can do it all.

Just call 1-866-456-7739 (TTY call 711), Monday – Friday, 8 a.m. – 4:30 p.m.

Routine Vision and Eyewear

If you need to find an in-network provider, visit **davisvision.com** and select **Eye Care Professionals**.

As a Highmark Medicare Advantage member, you're covered for urgent and emergency care worldwide.

Discover supplemental benefits.

Your plan **may** include additional benefits beyond standard coverage. Make sure to check the **Summary of Benefits** to see if these benefits are included.

Dental

Some plans give you routine dental coverage, such as:

- Cleanings.
- Crowns.
- Dentures.
- Extractions.
- Fillings.
- X-rays.

Vision

Some plans give you routine vision coverage, such as:

- Annual routine eye exam.
- Glasses or contacts.

Fitness

Get access to over 17,000 gyms and studios across the country, plus a large library of digital fitness classes. To explore your options, visit **medicare.highmark.com**. Click **Learn**, enter your **ZIP** code, then click **Plan Perks and Services** and then **Highmark Fitness**. Or, call us at **1-866-456-7739** (TTY call 711), Monday – Friday, 8 a.m. – 4:30 p.m.

Hearing

Some plans give you routine hearing coverage, such as:

- Routing hearing exams.
- Hearing aids.

Chiropractic Care

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

Podiatry Care

Some plans give you access to routine podiatry visits through a participating provider. Check the Summary of Benefits for the number of covered visits per year.

Extra perks to get care, get answers, and stay healthier.

Blues On Call SM

Answers from a health pro, 24/7.

Medical concerns during off hours? Just call **1-888-BLUE-428** (TTY call 711) to get support from a registered nurse or a health coach anytime and put your worries to bed.

Travel Benefits (PPO)

Coverage that travels with you.

With shared access to many Blue Plans' Medicare Advantage networks across the country, you don't have to worry about finding in-network coverage away from home. Happy trails.

Virtual Visits

Meet face-to-face with a doctor, 24/7.

Need to see a doctor but can't leave home? Get a diagnosis, treatment plan, or prescription anytime, right from your phone or computer. Just call **1-866-883-7358** (TTY call 711).

No Referrals

No referrals, no red tape.

Lose the time-wasting of going to an appointment just to get another appointment. See the in-network doctors you want to see. No hoops, no hoopla.

Rewards

Get rewarded for taking care of yourself.

As a Highmark 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 can join 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.

To learn about preventive-care-based reward and wellness card programs available to all Highmark Medicare Advantage members, visit **medicare.highmark.com**.

Highmark House Call

Once-a-year, in-home health review.

Get a general wellness exam, suggestions for screenings or other tests, and a medicine review.

Understanding 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.

Lowest cost to you → **Highest cost to you**

Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Preferred generic drugs	Generic drugs	Brand-name drugs	Non-preferred drugs	Specialty drugs

The three stages of Medicare prescription drug coverage.

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.

Stage 2 – Initial coverage

You pay the regular tier copay or coinsurance for your prescriptions. Once the total cost of your medications reaches $2,400, you move to Stage 3.

Stage 3 – Catastrophic coverage

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

Understanding your drug formulary

Getting to know the basics about your drug formulary can help save you money — and headaches — when it's time to get a prescription filled. That's why we've created this helpful guide to answer some of the most commonly asked questions.

What is a formulary?

The formulary is a list of FDA-approved prescription drugs and selected over-the-counter medications. The drugs on the formulary are divided into major categories, depending on the medical condition they are used to treat.

All of our 2027 plans use the Performance or Incentive formularies. For a complete list of every drug that's covered, you should refer to your plan's formulary.

How do I find my plan's formulary?

Your plan's formulary type is located at the top of the Part D Prescription Drug Benefits page of the Summary of Benefits.

How do I find out what drugs are covered?

There are two ways to find the list of drugs covered under your plan's formulary.

Option 1

Search for a drug at medicare.highmark.com.

You can use our search tool to find a specific drug. Visit **medicare.highmark.com**, scroll to the bottom of the page, and click the **Find a Prescription Drug** option. If you need additional help, give us a call at the number below.

Option 2

Get a hard copy of your drug list in the mail.

To request a printed copy of your plan's formulary, call us at the number below.

We can help you find what you need. Just call **1-866-456-7739** (TTY call 711), Monday – Friday, 8 a.m. – 4:30 p.m.

Save money by using preferred pharmacies.



Highmark Blue Cross Blue Shield works with many major pharmacies to help keep your prescription drug costs lower. You may save money by filling your prescriptions at one of the preferred pharmacies.

To find pharmacies near you, you can locate them online or request a Provider and Pharmacy Directory.

Be sure to review your Summary of Benefits to understand your coverage and confirm whether your plan qualifies for preferred cost sharing.

Costco, Sam's Club, Tops Pharmacy, Walmart, Wegmans Pharmacy, Express Scripts Mail Order, and some independent pharmacies.

Pharmacy network is subject to change.

If you need help finding a preferred cost-sharing pharmacy, call **1-866-456-7739** (TTY call 711), Monday – Friday, 8 a.m. – 4:30 p.m.

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.

How do I order mail-order prescriptions?

1. Ask your doctor to send your prescriptions electronically to the Express Scripts Pharmacy.
2. Call Express Scripts at **(800) 282-2881** or go to **express-scripts.com** and register for an account.

Have questions after you enroll? Just call the phone number on the back of your member ID card and we'll be happy to help.

How can I get extra help with prescription drug plan costs?

You may be able to get extra help for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- **1-800-MEDICARE (I-800-633-4227)**. TTY/TDD users should call **1-877-486-2048**, 24 hours a day, seven days a week.
- The Social Security Administration at **1-800-772-1213** between 7 a.m. – 7 p.m., Monday – Friday. TTY/TDD users should call **1-800-325-0778**.
- Your state Medicaid office.

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 or acquired immunodeficiency syndrome (HIV/AIDS)
  - Hypertension
  - Mental health (including depression, schizophrenia, bipolar disorder, and chronic or disabling mental health conditions)
  - 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 $1,600 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 (1-800-633-4227)**. 24 hours a day, seven days a week. TTY users should call **1-877-586-2048**.

Questions about your plan? We have answers.

Is my plan a Medicare Supplement?

No. Your plan is a Medicare Advantage HMO, not a Medicare Supplement. This means you have all the benefits of Medicare, plus extra perks.

What's included in my plan?

All Medicare benefits are covered, such as annual checkups, immunizations, and screenings. You may also have extra perks, like coverage for routine hearing and eye exams, hearing aids, eyeglasses or contact lenses, and prescription drugs. Please refer to the Summary of Benefits included in this kit for benefits and cost sharing. If you're enrolled in a PPO plan, you have the flexibility to choose doctors and hospitals both in and out of network. Referrals are not required for any Highmark Medicare Advantage plans.

Take a look at your benefits chart for more details on limitations, copayments, and coinsurance.

Will I receive high-quality care?

Absolutely. We carefully screen our health care providers before they join our network. Each provider is evaluated by our medical review committee and must meet strict criteria. We take these steps regularly to ensure we continue offering high-quality care.

Am I still covered by Original Medicare Parts A and B?

Yes. You still have Medicare coverage, but now it's through your plan. You don't pay Original Medicare deductibles and coinsurance, and you have extra benefits and services. You'll continue to pay your Medicare Part B premium, and you'll pay a copayment and coinsurance for certain network services and out-of-network care.

Am I affected by IRMAA?

Fewer than 5% of Medicare members are affected by IRMAA, Medicare's income-related monthly adjustment amount. If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit **medicare.gov/basics/costs/medicare-costs**.

What if I decide to drop my coverage later?

Before you disenroll, be sure to talk with Customer Service and follow the disenrollment steps outlined by your former employer or trust fund. If you drop coverage outside of an open enrollment period, you may be able to switch to a Medicare Supplement plan.

Health care lingo, translated.

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

Coinsurance

The percentage owed for some covered services. For example, if your plan pays 80%, you pay 20%.

Copay

The set amount you pay for a covered service. For example, it could be $20 for a doctor visit or $30 for a specialist.

Formulary

A list of prescription drugs your plan covers, including cost-sharing details and any coverage rules.

In-Network Provider

A doctor or hospital that charges no more than your plan allowance amount for their services.

Maximum Out-of-Pocket

The most you'd pay for covered care. If you hit this amount, your plan pays 100% after that.

Plan Allowance

The set amount your plan will pay for a health service, even if your provider bills for more.

Preferred Pharmacy

A network pharmacy where you may pay lower out-of-pocket costs for covered prescription drugs.

Premium

The monthly amount you pay to have coverage, in addition to your Medicare Part B premium.

Out-of-Network Provider

A doctor or hospital that usually charges more than your plan allowance for the same services.

Standard Pharmacy

An in-network pharmacy where covered prescriptions are available, but costs may be higher than at a preferred pharmacy.

IMPORTANT INFORMATION:

2026 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Highmark Blue Cross Blue Shield or Highmark Blue Shield - H3384

For 2026, Highmark Blue Cross Blue Shield or Highmark Blue Shield - H3384 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★☆
Health Services Rating:	★★★★☆
Drug Services Rating:	★★★★½

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 seven days a week, 8 a.m. – 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.

H3384_25_2092_M

Three easy steps to get you enrolled.

Step 1

Fill out everything on your Group Enrollment Application.

Complete all the sections on all the forms, or we can't process your application. If you're enrolling your spouse, they'll need to fill out the same set of forms, too.

Step 2

Double-check that your Medicare card information matches your application.

It's a red, white, and blue card with "Medicare Health Insurance" up top. If you want, you can include a copy of it with your application. (But that's not required.)

Step 3

Return your completed application in the envelope provided.

For enrollment questions or to get help completing your application, call **1-866-456-7739** (TTY call 711), Monday – Friday, 8 a.m. – 4:30 p.m.

In most cases, your coverage will start the first of the month following the month we get your completed application.

That means, if we get it in February, it kicks in March 1. But there are some situations that can push out that effective date, like:

- Information missing from your application.
- If your employer group has a different open enrollment period.
- If you're becoming eligible for Medicare Parts A and B for the first time.
- Certain special conditions and uncommon enrollment rules.

HIGHMARK

Because Life.™

Highmark Blue Cross 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:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, or Highmark Senior Health Company.

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company.

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

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

Express Scripts, Evernorth's pharmacy benefit services business, is an independent company that manages your prescription benefits for your health plan.

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

Davis Vision, Inc. is a separate company that administers Highmark vision benefits.

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 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, 1 territory and 1 district: Alabama, Arizona, 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, West Virginia, and Wyoming. For some of the states listed, MA PPO networks are only available in portions of the state.

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.

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

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo.



Because Life.™