

2026

Agent Field Guide

HIGHMARK MEDICARE ADVANTAGE,
D-SNP, AND ACA INDIVIDUAL MARKET



Confidential and Proprietary — For Agent Use Only

Dear Highmark Agent:

Welcome to Highmark Federal Markets — what we call our combined Highmark Medicare, D-SNP, and ACA Individual Market sales team. You're a valued member of this team, and the face of Highmark.

As a Highmark field agent, you're often our first point of contact with consumers who are shopping for quality health coverage that's both accessible and affordable.

With this in mind, we've put together our Agent Field Guide to equip you with the tools and references you need to assist your clients more effectively.

This Agent Field Guide puts a wealth of information at your fingertips — including details about our important policies, system navigation, and everything you need to know about doing business with Highmark. On the following pages, you'll also find guidance on using the Highmark producer web portal, information on the Medicare Star Ratings, and other insights to ensure you're ready to sell Highmark products.

Please keep this guide handy. It can help you prepare for more productive client meetings by understanding how to offer comprehensive coverage and real value in a health plan.

The Federal Markets Agent Product Guide is a separate resource that will include yearly benefit grids and maps for all three lines of business, in-network hospitals, and any updates for the new plan year. We will communicate and distribute the Agent Product Guide as soon as it is available.

Thank you for representing Highmark. Please know that we're always here to help make your job easier and support your successes.

Sincerely,

The Highmark Federal Markets Team

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SECTION I

Doing Business with Highmark Federal Markets

The Producer Portal

Highmark offers plenty of helpful resources to make your job easier — including our Producer Portal. This user-friendly website has everything you need to understand our plans and communicate effectively with clients.

With the Producer Portal, you can:

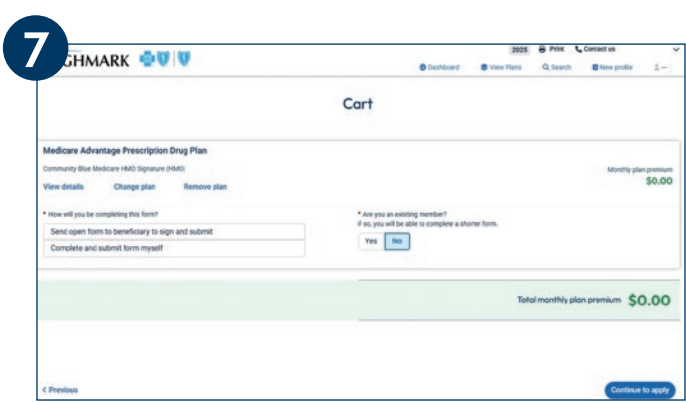
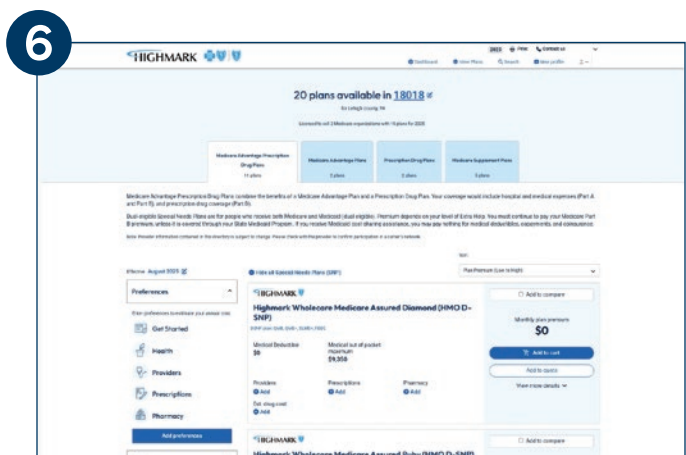
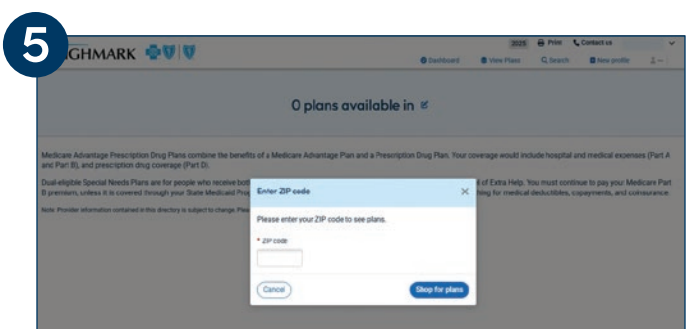
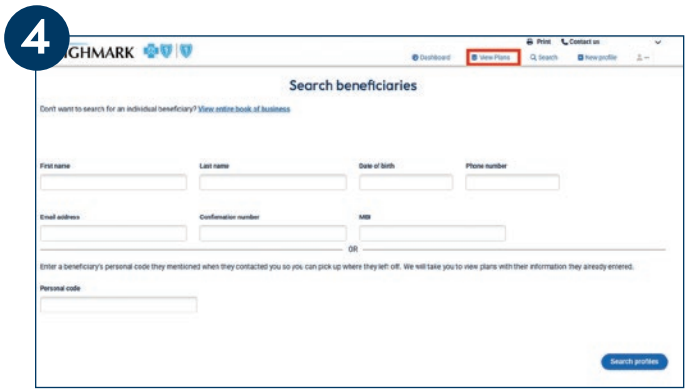
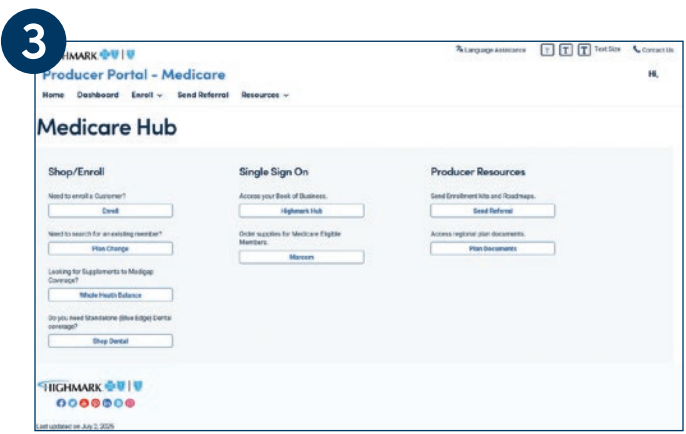
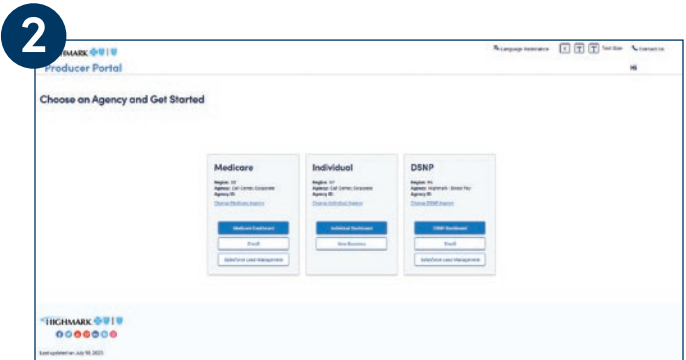
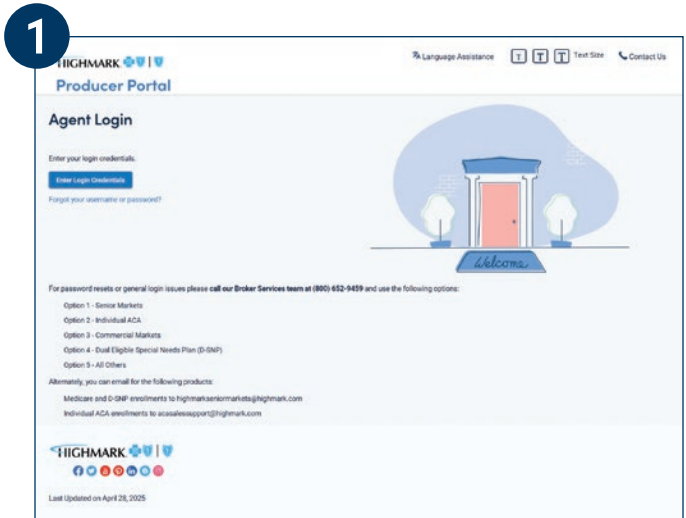
- Enroll clients online.
- Check the status of applications.
- Order enrollment kits.
- Request CMS-approved marketing materials.
- View and download important documents.
- Access the most recent version of this Field Guide.

MA and D-SNP

Enroll your clients in just a few steps

Our online enrollment tool simplifies the enrollment process — follow the steps below:

1. Log in to the **Producer Portal**, producer.highmark.com.
2. Access the relevant Line of Business by selecting **Dashboard**.
3. Select **Enroll** to initiate the enrollment process. Additional resources can also be accessed in the Hub.
4. From the **Search beneficiaries** page, click **View Plans**.
5. Enter the beneficiary's **ZIP code** and confirm their **County** (if prompted), then select **Shop for plans** to view available options.
6. This view allows you to verify in-network providers, prescriptions, and pharmacies, as well as compare plans. Select **Add to Cart** to choose a plan.
7. After selecting **Add to Cart**, follow the prompts to enter all required information.
8. Finally, review and submit the application. You will then be directed to a confirmation screen with the option to email or print.

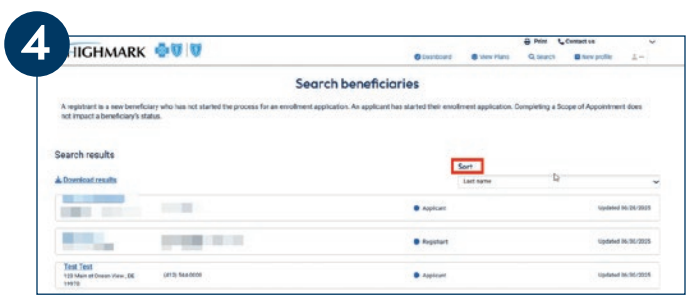
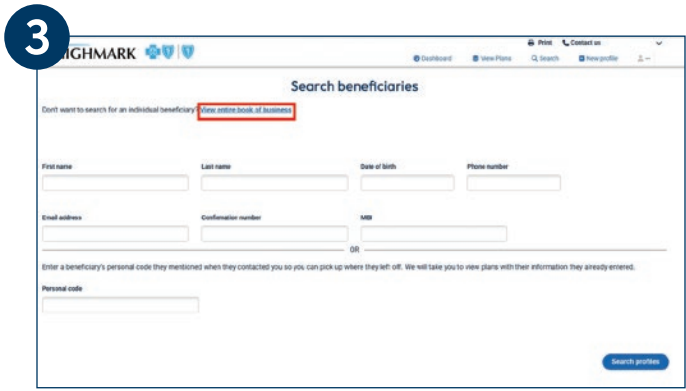
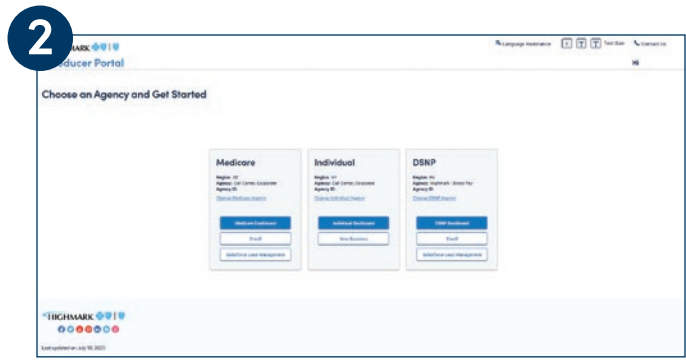
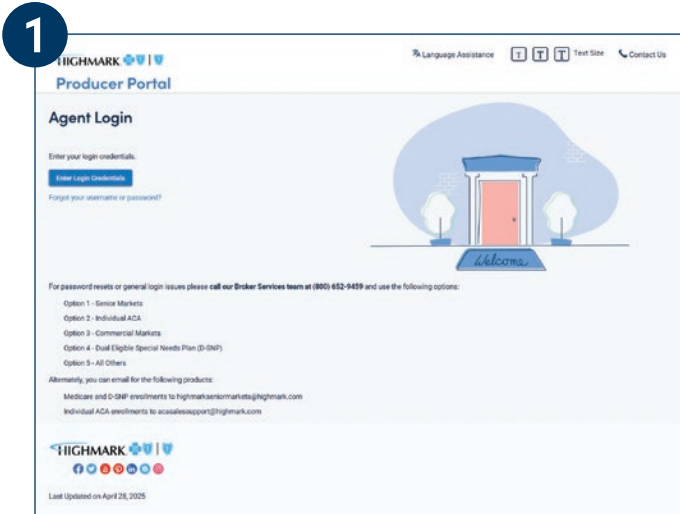


The Producer Portal, cont.

Checking the status of an application

After submitting an application to Highmark via online enrollment, you can track its status in the Producer Portal by following these steps:

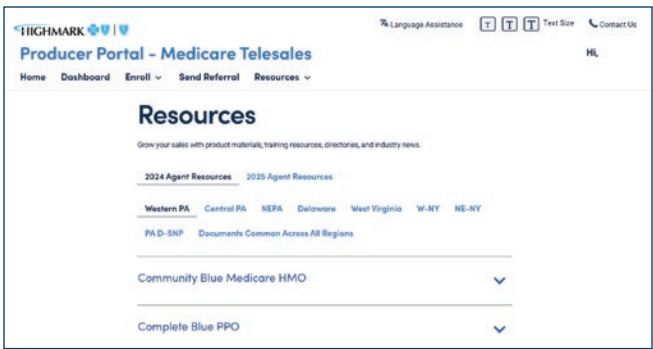
- 1. Log in to the **Producer Portal**, producer.highmark.com.
- 2. Navigate to the appropriate Line of Business Hub and select **Enroll**.
- 3. On the **Search beneficiaries** page, select the **View entire book of business** link.
- 4. You can then sort the results by criteria such as **Last Name**, **Status**, **Last Updated**.



Viewing and downloading documents

The Producer Portal provides access to important documents for marketing and selling Highmark Medicare and D-SNP products.

To find product materials, training resources, and directories for both Medicare and D-SNP, navigate to the appropriate Line of Business Hub and select **Plan Documents**. To order marketing materials, select **Marcom** for Medicare and **Fineline** for D-SNP within the respective Hub.



The Producer Portal, cont.

ACA

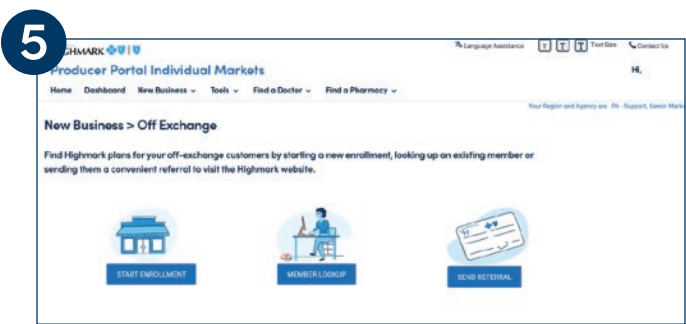
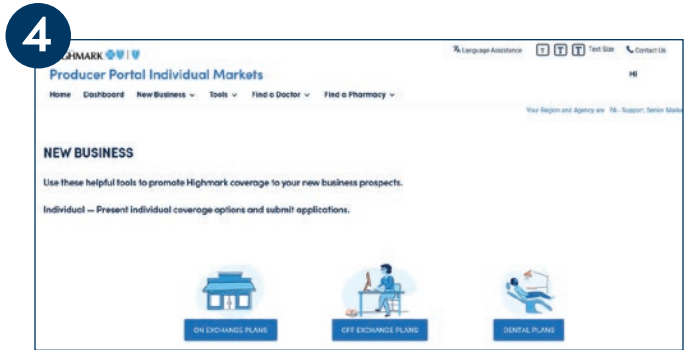
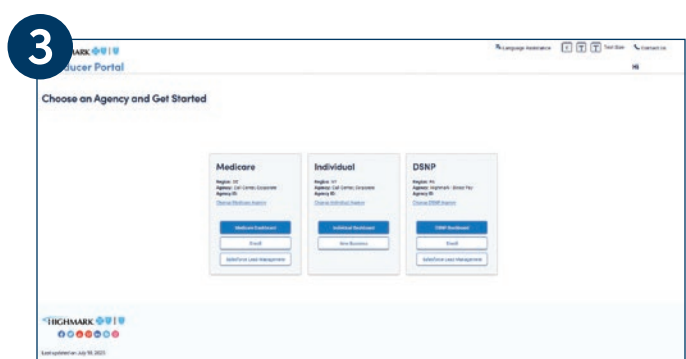
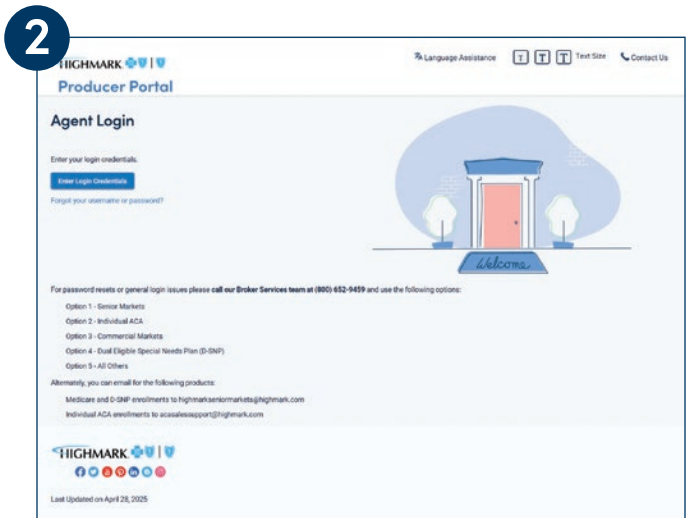
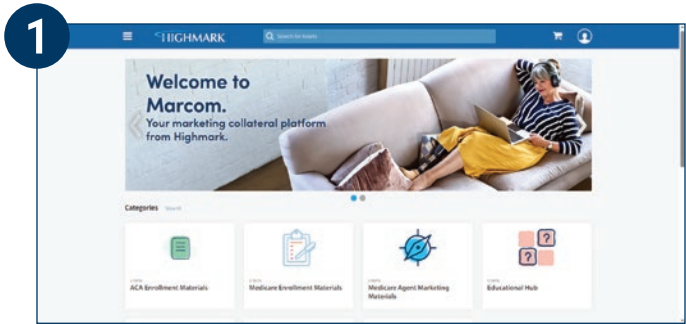
Enroll your clients in just a few steps

Our online enrollment tool simplifies the enrollment process — follow the steps below.

Here’s how to use the online enrollment tool:

1. Log in to the **Producer Portal**, producer.highmark.com.
2. Under the **Individual** Line of Business, select **New Business**.
3. Choose either **On-Exchange Plans** or **Off-Exchange Plans**.*
4. After choosing Off-Exchange, select **Start Enrollment** to initiate the enrollment process.
5. Enter the beneficiary’s **ZIP code**, select the **County**, then choose **Next** to view plans and make a selection.
6. Once you complete the application, you will be directed to the review screen to print a summary. After submission, a confirmation screen will appear, where you can email a confirmation for your records.

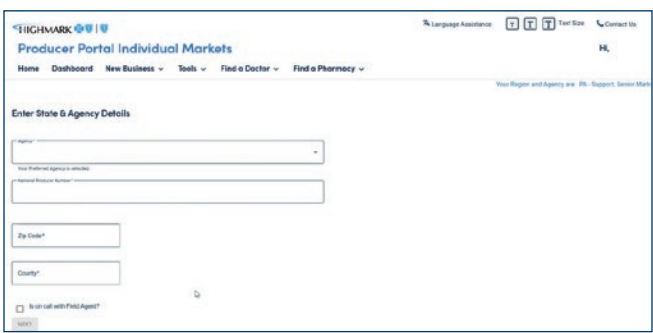
*Note: Online enrollment for Off-Exchange plans is only available during the Open Enrollment Period. If you select On-Exchange, you’ll be taken to the appropriate state-based or FFM exchange.



Viewing and downloading documents

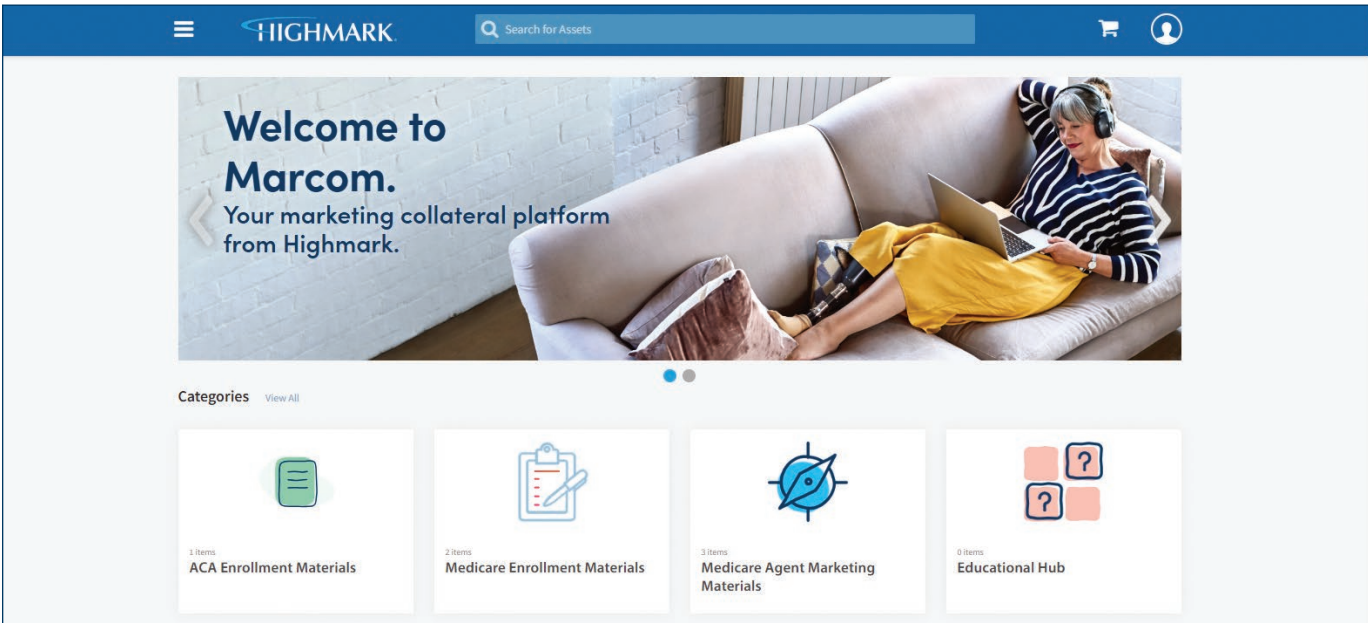
The Producer Portal provides access to important documents for producers marketing and selling Highmark ACA products.

To view and download these documents, navigate to the **Tools** dropdown menu and select **Resources**. All available documentation will be listed, organized by product and region. This includes applications, rate guides, and marketing materials.



Using Marcom — our online source for enrollment kits and support materials

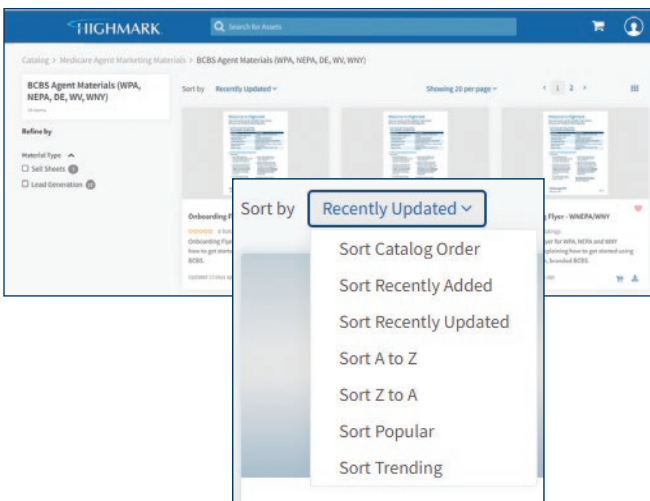
Highmark agents have one website for all of their marketing materials and enrollment kits. To get started, log in to **Highmark Producer Portal** at producer.highmark.com. You can access Marcom through the Medicare Hub via Single Sign On. Please Note: D-SNP marketing materials and enrollment kits can be accessed through the D-SNP Hub via Finline.



How to navigate

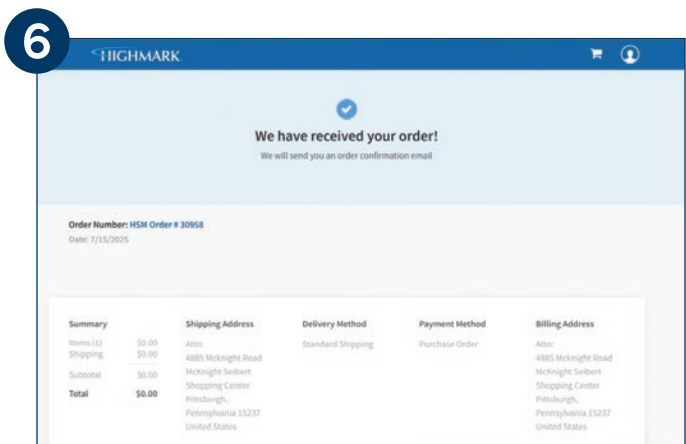
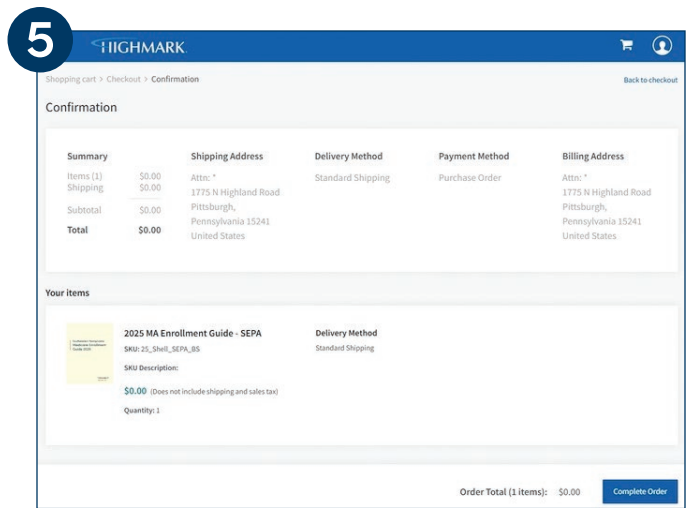
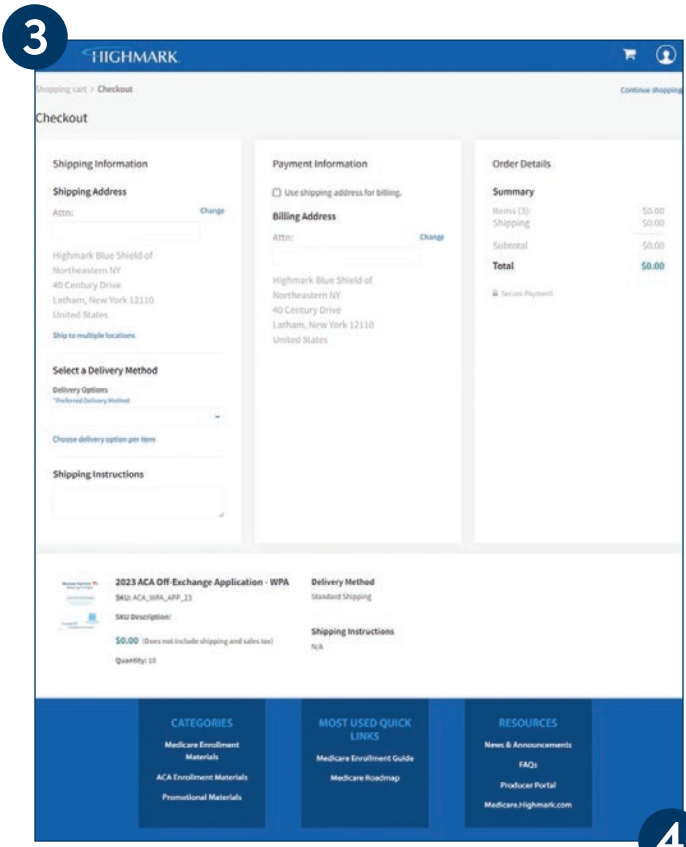
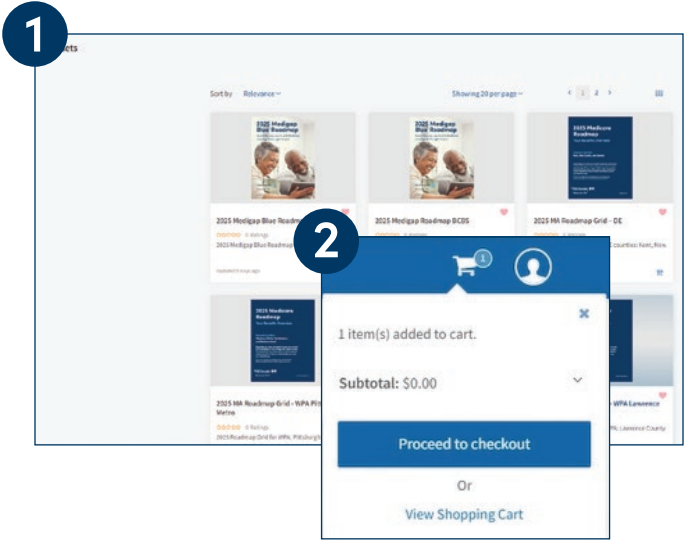
You can search on Marcom a few ways:

1. **Typing in the Search Bar.**
2. **Scrolling** through the pages.
3. **Home Page view/toggling** between the different view options.
4. Use the filter feature to narrow your search by either sell sheets or lead generation materials.



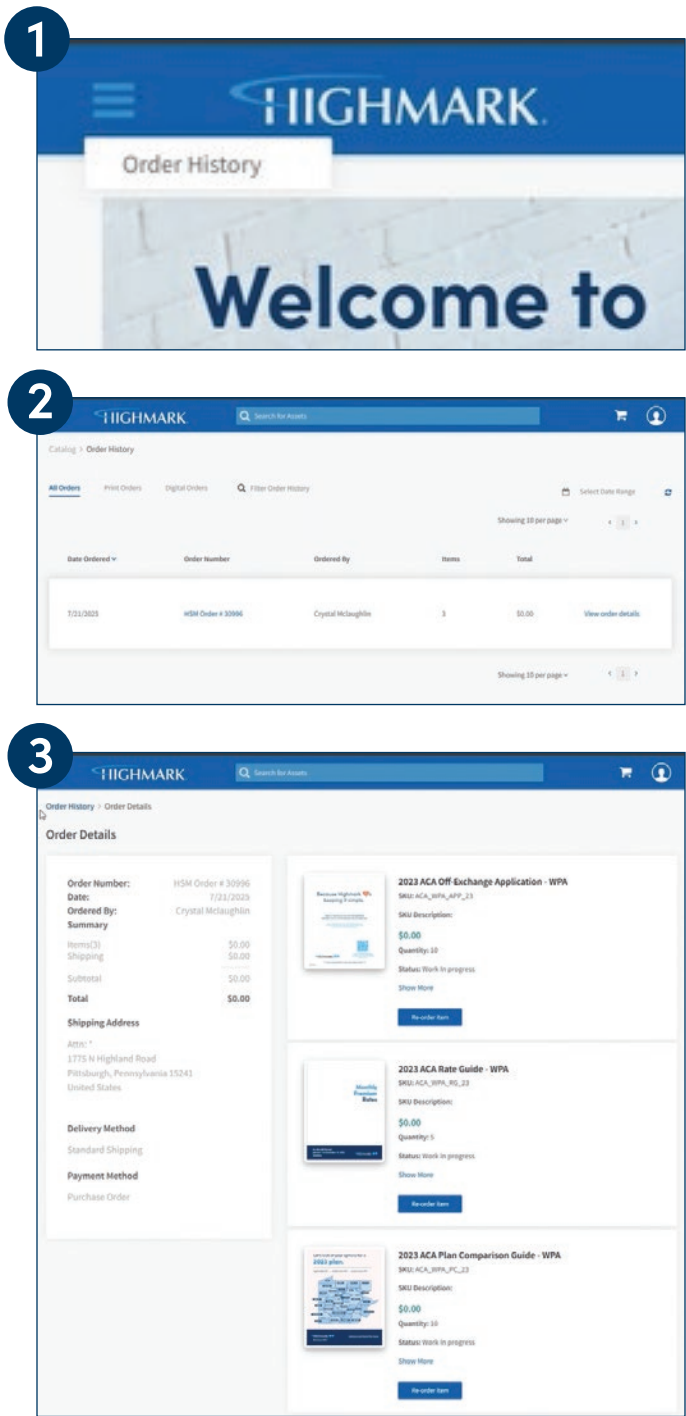
How to check out

1. Identify the product you would like to order and select the **Add to Cart** button at the bottom of the page. If the piece requires customization, you must complete that first and then select **Add to Cart** after generating a proof.
2. Once you add to the cart, a preview will show in the top right of the page.
3. Select the **View Shopping Cart** or the **Proceed to Checkout** button to begin the checkout process. You'll be asked to fill out your **Shipping and Billing Information**. Once you've completed that, hit **Refresh order details** at the bottom to apply your changes to the order.
4. Select the **Review and Confirm** button.
5. Review your order details and select **Complete Order**.
6. Your order is placed, and you will receive your order number.



How to check order history

- 1. To check on past orders, navigate to the menu icon in the top left corner and select **Order History**.
- 2. You'll see all orders listed by date. You can also search by order number, date range, and more.
- 3. Select the **View order details** link to see which items were included in each order. You will also be provided a link to reorder if you'd like.



How to talk to your clients about eBill

The easiest way to pay

Coverage starts once a member reaches their coverage effective date and makes their first payment. The simplest way to do that is by registering for an eBill account. After that, they can set up automatic payments to make paying on time even easier. Here's how to get started:

- 1. **Create an account** by visiting our secure member website and selecting the **Register** link. They'll need their Highmark member ID.
- 2. **Receive and pay the first invoice.**
- 3. **Set up automatic payments**, so they never miss one. Missing a payment can lead to loss of coverage.

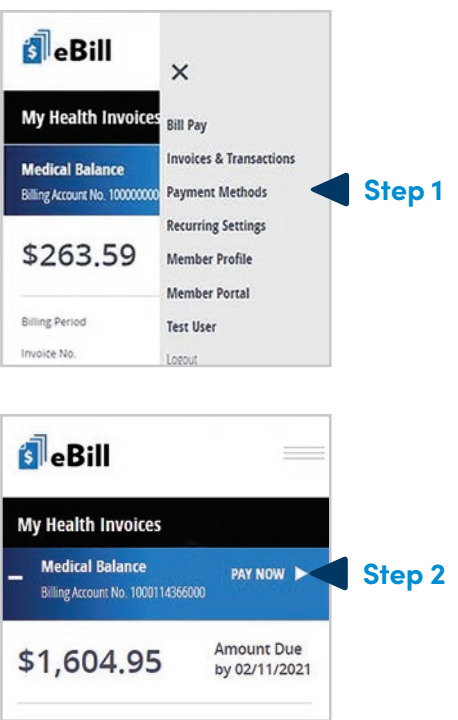
Making payments

Step 1:

Members can log in to their account and select the **Pay Premium** tab. This will take them to the eBill landing page. If they're using a mobile device, they can click the three lines in the upper right-hand corner to access the menu.

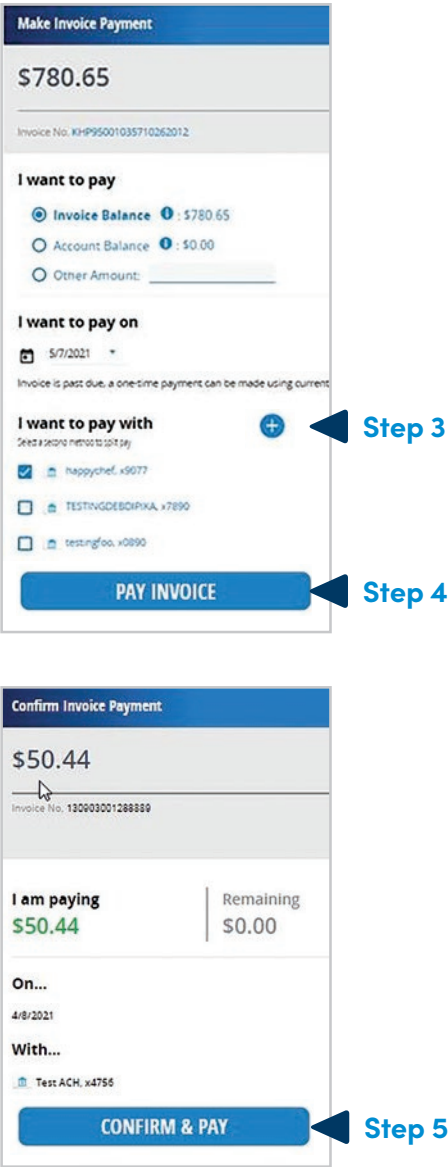
Step 2:

Under **My Health Invoices**, they can find their invoice and tap **Pay Now** in the blue bar.



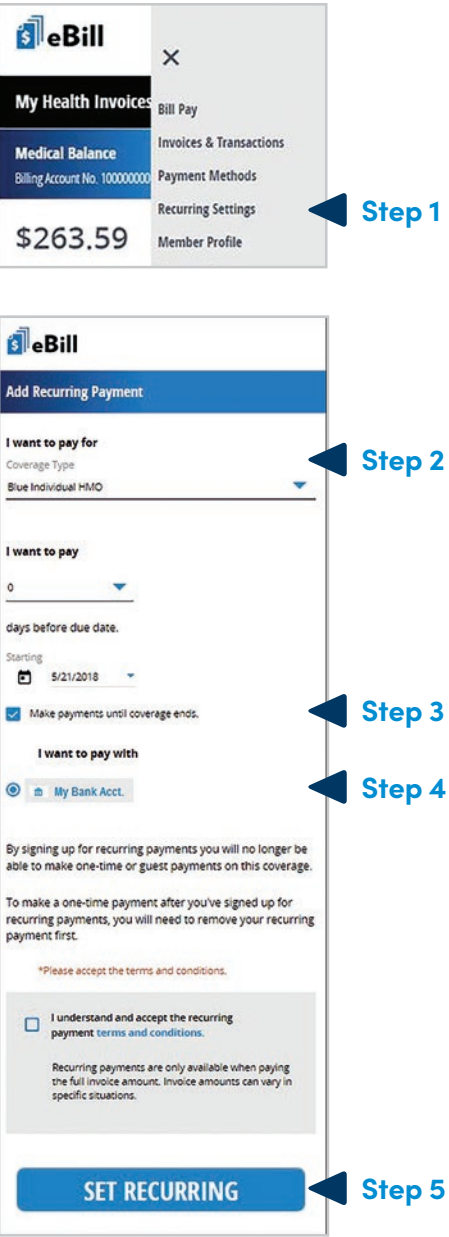
How to talk to your clients about eBill, cont.

- Step 3:**
- Next, they'll need to add a payment method.
- They can tap the blue plus symbol to the right of **I want to pay with**. From there, they can enter the details of their preferred payment method, then tap **Add Payment**.
- Step 4:**
- Once their preferred payment method is added, they should tap **Pay Invoice**.
- Step 5:**
- On the **Confirm Invoice Payment** page, they can make sure all the information is correct and then tap **Confirm and Pay**.



Signing up for automatic payments

- Step 1:**
- Members can go to **Recurring Settings** on the main menu and tap **Add Recurring Payment**.
- Step 2:**
- Select the **Coverage Type** from the drop-down menu.
- Step 3:**
- Select the number of days before the due date to pay the bill from the drop-down menu (0 – 10), then select a starting date for the recurring payment.
- If the box below the starting date is unchecked, a second box will appear for the ending date. **Make payments until coverage ends** is the default.
- Step 4:**
- The member's preferred payment method will automatically be selected. If they want to use multiple payment methods, they can uncheck the preferred payment method and choose another.
- Step 5:**
- Tap the checkbox to accept the terms and conditions, then click **Set Recurring**.



Ethics and Integrity

Highmark Health and its Blue-branded health plans are committed to complying with all applicable federal and state regulatory requirements.

Highmark Health and its affiliates/subsidiaries’ policies and procedures deal with direct black-and-white types of situations. But more often than not, life happens in gray areas. This is where the Code of Business Conduct comes in.

The Code outlines Highmark Health’s ethical standards and behavioral expectations. You are required to read, understand, and agree to abide by the Highmark Health Third Party Code of Business Conduct.

As an appointed agent, you have the responsibility to comply with our Third Party Code of Business Conduct.¹ You are required to conduct business activities and interactions ethically and with integrity. You must adhere to the following standards:

- Seek to truthfully, carefully, and accurately present a true picture of covered benefits by learning about and keeping abreast of all relevant products, benefit plans, and applicable legislation and regulation, to the best of your ability.
- Make a conscientious effort to ascertain and understand all relevant circumstances pertaining to the client in order to recommend appropriate benefit plans.
- Inventory current benefit plans with the client to avoid selling duplicative insurance benefits.
- Honestly assess the likelihood that a client will meet underwriting and financial requirements and discover any adverse factor(s) to reduce false expectations of acceptance and adequacy of benefit plan.

- Possess a comprehensive understanding of products in order to honestly, openly, and effectively portray benefit plans and determine a client understanding of key benefits and limitations.
- Clarify and verify the client’s grasp of information and review pertinent issues.
- Protect proprietary and competitive information.
- Protect protected health information and confidential and financial information in compliance with existing state and federal laws and regulations.
- Obey all laws, including antitrust, governing business, and professional activities and represent products in an ethical manner without fraud, misrepresentation, exaggeration, coercion, scare tactics, or concealment of pertinent facts.
- At all times, fully disclose commission and compensation arrangements to the client.
- Ensure appropriate relationships by not offering or accepting any inducements that might compromise a reasonable business decision. Avoid any conflict of interest or the appearance of any conflicts of interest.
- Use only authorized promotional materials unless prior written approval has been obtained, and fairly focus your presentation on positive benefit comparisons, rather than disparaging remarks about the competition.
- Treat a client or a potential client with courtesy, respect, and priority, in accordance with thoughtful, ethical, and legal business practices.

¹ A copy of Highmark Health’s Third Party Code of Business Conduct can be found at highmarkhealth.org/hmk/pdf/highmarkHealthThirdPartyCodeBusinessConduct.pdf.

You are obligated to report any questionable behavior by employees of Highmark Health and/or its subsidiaries/affiliates, a third party, and/or its employees and agents or potential noncompliance situation, or if you suspect potential or actual fraud, waste, or abuse (“FWA”), you should contact the Highmark Health Integrity and Compliance Department. In addition to being a resource for Highmark Health employees, the Integrity and Compliance Department is available for questions by Highmark Health business agents like you. When a report is made to the Integrity and Compliance Department, appropriate action is taken to review and/or investigate the report to reduce the potential for recurrence and ensure ongoing compliance. Third Parties are expected to cooperate with the investigation of a suspected violation of this Third Party Code or violation of any governmental law or regulation. In addition, as required and/or appropriate, the Integrity and Compliance Department may disclose investigation matters to applicable law enforcement or regulatory entities. Failure to promptly report a known violation may result in action up to and including termination of the business relationship and is the sole discretion of Highmark Health.

There are various methods for reporting concerns:

- 24/7 Helpline: **800-985-1056**
- U.S. Post Office Box: **Highmark Health Integrity and Compliance Department, P. O. Box 22492, Pittsburgh, PA 15222**
- Fax: **412-544-2475**
- Email: **integrity@highmark.com**

All inquiries to the Integrity and Compliance Department are confidential, subject to limitations imposed by law. When using the Integrity Helpline, you may remain anonymous. If you choose to make an anonymous report, you should provide enough information about the situation to allow the Integrity and Compliance Department to properly perform an investigation. If you do not provide enough details, the ability to pursue the matter will be limited. Highmark Health maintains a reprisal-free environment and has a policy of non-retaliation and non-intimidation to encourage employees, Third Parties, and their employees to raise ethical or legal concerns in good faith. Third Parties who raise questions or report concerns regarding potential or actual FWA matters in connection with any of Highmark Health’s government programs are protected from retaliation and retribution for False Claims Act complaints, as well as any other applicable anti-retaliation protections. All inquiries are confidential, subject to limitations imposed by law. The Third Party Code sets forth general principles with which Third Parties must comply. More restrictive requirements may be set forth in the contracts between Third Parties and Highmark Health.

Commissions, Compliance, and Agent Oversight*

Compensation

Compensation includes monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and referral/finder’s fees.

Compensation **DOES NOT** include:

- The payment of fees to comply with state appointment laws.
- Training.
- Certification.
- Testing costs.
- Reimbursement for mileage to, and from, appointments with beneficiaries.
- Reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

Commissions

We pay a commission to agents for each person they enroll in a Highmark product in accordance with the CMS requirements, agent eligibility, and our commission schedules. The compensation year is Jan. 1 – Dec. 31, regardless of beneficiary enrollee date.

To qualify for commissions, agents must:

- Not be on Office of the Inspector General (OIG) and/or the General Services Administration’s (GSA) System for Award Management (SAM). We check them initially and every month thereafter.
- Complete the contract, state licensing, appointment, and certification process prior to the sale of the policy. **(You will not receive commissions for applications submitted before all contracting and certification requirements are met.)**
- Complete the annual certification process, including market-specific product training(s) to receive renewal commission for policies active in the current year, and meet other requirements set forth in your contract.
- Be in good standing with their plan. Disciplinary action may result in the disqualification of commission.
- Please refer to your appointment documents and/or the General Producer Agreement for more information about eligibility for commissions.

In addition, to receive renewal commission in January for business sold in prior years, you must complete the annual certification process by Dec. 31.

*Note: If you choose to recertify **after** Dec. 31, your prorated renewal commission payments will resume the first month after certification is complete. You will not be eligible for any missed commission payments during your lapse period.*

* Per CMS guidelines, some information may only pertain to Medicare.

Compliance

Highmark is committed to full compliance with federal and state regulatory requirements applicable to its Federal Markets plan business.

Highmark, its employees, and contractors are expected to meet the contractual obligations set forth in the company’s contracts with the Centers for Medicare and Medicaid Services (CMS).

In order to achieve these objectives, Highmark conducts its business in compliance with — and does not tolerate any violation of — applicable federal and state health care regulations.

Potential consequences of engaging in inappropriate or prohibited marketing activities include disciplinary actions, termination, and forfeiture of compensation.

Agents for Highmark’s covered programs are required to comply with the ACA Section 1557 regulations as of July 18, 2016. Any agent who engages in prohibited discrimination in connection with the marketing of a Highmark-covered program will be subject to disciplinary action including the termination with cause of their Producer Agreement.

At the time of contract, the following will be verified:

- Active License (with Accident and Health Line of Authority)
- Annual Certification (including the Annual FWA and Compliance training and Integrity training)
- Appointments to the appropriate Highmark companies

In addition, ongoing communication will occur through emails, webinars, group meetings, and one-on-one consultations. Training will reinforce the need for strict compliance and will advise producers that any failure to comply will be documented and may result in disciplinary action up to and including possible termination.

Agent oversight

Highmark employs several monitoring procedures to ensure that certified agents are complying with all CMS sales and marketing guidelines and Highmark Federal Markets Sales policies. If any compliance deficiencies are identified through these monitoring procedures, the agent is subject to the disciplinary action process outlined later in this section. Violations could result in receiving education, non-commissionable sales, or even termination.

These procedures include:

Secret-shopper evaluations

- Highmark utilizes a vendor to conduct periodic secret-shopper evaluations of producers selling Highmark Medicare products.
- Highmark Federal Markets Sales reviews the evaluations reported to verify that the producer is complying with all applicable CMS sales and marketing guidelines.

Telephonic phone surveys

- Highmark calls a random sample of members enrolled through producers as part of the New Member Welcome Call process and requests that the member complete a survey addressing the producer sales process.

Complaint/allegation tracking

- Highmark investigates, monitors, and tracks any and all complaints that are received against producers.

Untimely application tracking

- Highmark investigates, monitors, and tracks any and all applications received after 48 hours.

Scope of appointment audits

- Highmark expects that all agents maintain complete and separate records of all transactions and documents pertaining to applications submitted to and accepted by Highmark for a period of at least 10 years after the contract year.
- To ensure that all producers are complying with the CMS guidelines that require records to be kept for 10 years, a random sample of agent-submitted agreements will be selected and the agent will be required to provide the Scope of Appointment.

Rapid disenrollment and cancellation tracking

- Highmark’s Producer Agreement stipulates that:
 - The total initial or renewal commission will be charged back if the enrollee disenrolls in an unreasonably short time frame (i.e., rapid disenrollment).*
 - Upon receipt of a notice of disenrollment that occurs three months or more after enrollment, Highmark will withhold or withdraw (“chargeback”) commission payments on a pro-rata monthly basis to the effective date of the disenrollment.
 - Highmark will also assess chargeback for rapid disenrollments in accordance with CMS guidelines.

* An “unreasonably short time frame” is defined as less than three months after enrollment.

Sales and marketing events

During marketing/sales events, plan representatives may discuss plan-specific information (i.e., premiums, cost sharing, and benefits), distribute health plan brochures and enrollment materials, and accept and perform enrollments.

There are two types of sales and marketing events

(Both follow the same CMS marketing guidelines.)

- **Formal:** Typically in an audience/presenter format with an agent, broker, or producer formally providing specific plan or product information via a presentation.
- **Informal:** Conducted with a less structured presentation or in a less formal environment. Typically utilizes a table, a kiosk, or a recreational vehicle (RV) staffed by a plan representative who can discuss the merits of the plan’s products. Beneficiaries must approach you first.

Key requirements and important notes

- Use only our CMS-approved sales scripts, presentations, and sales presentations notes/talking points during all Highmark marketing/sales events.
- Formal and informal marketing/sales events do not require documentation of beneficiary agreement on a Scope of Appointment form. Do not request or obtain one. CMS views this as pressuring for personal contact information.
- A beneficiary may complete a Scope of Appointment at a marketing/sales event for a future appointment.
- Upon arrival to an informal or formal event, check in with the venue so they know you are on site, and have the verification form signed at that time.

- Do not market non-health-care-related products such as annuities and life insurance (cross-selling) to prospective enrollees during MA/MAPD or PDP marketing/sales events.
- All marketing/sales events must meet event requirements. Exception: If only one beneficiary attends a formal event, you can discuss the MA/MAPD and/or PDP products on an individual basis (must go with attendee’s preference — full presentation or informal discussion). A Scope of Appointment is not required under this exception.
- You will not receive commission for any sale that results from an unreported marketing/sales event. Failure to report events can result in termination of your Highmark contract.
- New agents received marketing/sales event reporting information during their certification training. This information is also located in agent annual training/testing material, CMS Medicare Marketing Guidelines, this Highmark Medicare Producer Guide, and on the Highmark Producer Portal.
- All documentation must be saved for at least 10 years and available upon request by Highmark or CMS.

Prohibited activities

- Conducting health screening, genetic testing, or other like activities that give the impression of “cherry picking.”
- Requiring beneficiaries to provide any contact information as a prerequisite for attending an event. This includes requiring an email address or any other contact information as a condition to RSVP for an event online or through the mail.
- Using personal contact information for any other purpose other than to notify individuals of a raffle or drawing winning.
- Comparing Highmark to another organization or plan by name unless you obtain written consent from all organizations or plans being compared. You must provide this written consent to us for submission to CMS.

- Providing meals to attendees. However, light snacks and refreshments are permitted.
- Asking a beneficiary for a referral.
- Soliciting or accepting an enrollment application for a Jan. 1 effective date prior to the start of the Annual Enrollment Period (Oct. 15 – Dec. 7) unless the beneficiary is entitled to another enrollment period.
- Marketing or advertising Medicare plans or events for the upcoming plan year prior to Oct. 1.
- Using absolute superlatives like “the best,” “highest ranked,” or “rated number 1,” or qualified superlatives like “one of the best,” or “among the highest ranked,” unless they are substantiated with supporting data provided to CMS as a part of the marketing review process.
- Claiming you or Highmark are recommended or endorsed by CMS, Medicare, or the Department of Health and Human Services.
- Offering nominal gifts in the form of cash or other monetary rebates, even if their worth is \$15 or less. Cash gifts include charitable contributions made on behalf of potential enrollees, and gift certificates and gift cards that can be readily converted to cash.

CMS consent to aid requirement: ACA

CMS requires agents and brokers who are helping consumers apply for and enroll in Marketplace coverage to document receipt of consent from the consumer, or the consumer’s authorized representative, prior to aiding in the application process.

- To satisfy this requirement for Pennsylvania, Delaware, and West Virginia, Highmark utilizes the CMS Model Consent form.
- This documentation must be retained for 10 years.

Scope of Appointment form

The Centers for Medicare and Medicaid Services require agents to document the scope of a marketing appointment prior to any face-to-face or telephonic sales meeting to ensure understanding of what will be discussed between the agent and the beneficiary.

If the agent would like to discuss additional products during the appointment, the agent must document a second Scope of Appointment (SOA) for the additional product type.

- It is the responsibility of the agent to secure an SOA for every sales appointment.
- The agent must retain a copy of the SOA for 10 years after the contract year per CMS regulations – whether an enrollment is received or not.
- All information provided on the form is confidential and should be completed by each person with Medicare.
- When conducting a sales meeting, the agent may not market any health care-related product beyond what was agreed upon on the SOA form.

Note: A copy of the Highmark Scope of Appointment (SOA) can be found at the end of the Medicare Advantage and D-SNP Sections.

You must gather a SOA form at least 48 hours before speaking to anyone about plans, and only speak of the specific plans they ask about. In other words, personal marketing appointments may not take place until 48 hours since the time the SOA is completed by the beneficiary.

These are two exceptions to this rule:

- When the prospect is within four days of the end of the enrollment period.
- When there is a walk-in appointment or inbound call where the beneficiary is expressing interest in enrollment.

Keep in mind, these are general guidelines and do not encompass every scenario.

Third Party Marketing Organization (TPMO) disclaimer requirements

TPMOs must use the new standardized disclaimer:

We do not offer every plan available in your area. Currently, we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact [medicare.gov](#), **1-800-MEDICARE**, or your local State Health Insurance Program (SHIP) to get information on all of your options.

If a TPMO sells for all Medicare Advantage Organizations in a service area, they are required to use the following disclaimer:

Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact [medicare.gov](#), **1-800-MEDICARE**, or your local State Health Insurance Program (SHIP) for help with plan choices.

TPMO compliance obligation

Further, TPMOs understand that the TPMO shall not share personal beneficiary data with other TPMOs for marketing or enrollment purposes unless a prior express written consent is obtained from the beneficiary that allows the TPMO to share that information with other TPMOs. The prior express written consent from the beneficiary to share the data and be contacted for marketing or enrollment purposes must be obtained through a clear and conspicuous disclosure that lists each entity receiving the data and allows the beneficiary to consent or reject to the sharing of their data with each individual TPMO.

The following five activities are mandatory.

You must:

1. Report all marketing/sales events prior to advertising the event or 21 days prior to the event’s scheduled date, whichever is earlier.
2. Use one of our CMS-approved sales presentations from beginning to end every time you meet with a beneficiary to discuss our products and read the sales presentation notes/talking points as part of the script. The sales presentation video must use in conjunction with the CMS-approved sales presentation.
3. Announce all products or plan types to be covered during the presentation at the beginning of the presentation (i.e., HMO, PPO, PDP, etc.).
4. When providing an enrollment form, you must also provide the following materials: 1) Star Ratings information, 2) Summary of Benefits, and 3) Multi-Language Insert.
5. If using non-Highmark sign-in sheets, clearly write in large letters across the top: “Completion of any contact information is optional.”

Agent Disciplinary Policy for Minor and Severe Violations

Minor violations

Minor violations are taken seriously and may require immediate disciplinary action. Disciplinary action may include, but is not limited to, withholding commissions and/or the retraction of commissions. The results of each investigation will be reviewed by the Federal Markets Sales Department to determine the appropriate disciplinary action. Minor violations are tracked over a rolling two-year period.

Violations in this category include, but are not limited to:

- **Untimely broker application submissions**
 - Highmark requires applications to be submitted within 48 hours of signature from the customer. This pertains to both online enrollments and paper applications.
- **Rapid disenrollments**
 - Rapid disenrollments will be reviewed for any trends or patterns amongst individual agents.
 - Highmark’s Producer Agreement (Schedule C, Section B, Subparts 5 and 6) stipulates that:
 - » The total Initial or Renewal commission will be charged back (as set forth below) if an enrollee disenrolls in an unreasonably short time frame (i.e., rapid disenrollment). An “unreasonably short time frame” is defined as less than 90 days after enrollment.
 - » Upon receipt of a notice of disenrollment that occurs 90 days or more after enrollment, Highmark will withhold or withdraw (“chargeback”) commission payments on a pro-rata monthly basis to the effective date of the disenrollment. Highmark will also assess chargebacks for rapid disenrollments in accordance with CMS guidelines.

Minor violation disciplinary procedures

- **First Offense:** A first violation committed by the agent will result in an official warning to the agent and/or their general agency or FMO, as applicable, alerting them of the infraction.
- **Second Offense:** A second violation committed by the agent will result in a secondary warning and education on Highmark’s policies and procedures.
- **Third Offense:** A third violation will result in withholding or retraction of commissions on any sale or application(s) relating to the violation. Depending on the nature of the third offense, the commission retraction could be one or multiple applications relating to the offense. This is at the sole discretion of the Federal Markets Sales Department.
- **Persistent Minor Violations:** Disciplinary action for persistent minor violations may include, but are not limited to, suspension and/or termination of contract.

Any agent found to have committed a minor violation may be educated by the appropriate member of the Federal Markets Sales Department. The agent may be required to repeat the company’s sales training program before being permitted to resume selling Highmark Federal Markets products.

Committing a minor violation may be considered grounds for further action to be taken including, but not limited to, suspension, termination, and/or retraction of commissions.

- **Founded Complaints Tracking Module (CTM) or Member Service complaint**
 - Each complaint is independently investigated by a Highmark compliance individual.
- **CMS compliance violation during sales interaction**
- **Presenting competitor information during Highmark event or Highmark scheduled appointment**

Severe violations

Severe violations are noncompliant activities deemed egregious in nature, which may result in immediate contract suspension, termination, and/or retraction of commissions.

All allegations of severe violations are investigated by the Federal Markets Sales Department with support from the Compliance Department.

Violations in this category include, but are not limited to:

- Dishonesty or theft.
- Threatening, coercing, intimidating, or deceiving a member or prospective member, or the use of any other unethical sales tactics.
- Door-to-door solicitation.
- Misrepresentation of the product, the purpose of the producer’s visit, or an implication that the visit is in any way connected with the government.
- Forging or knowingly accepting a forged signature on an enrollment form.
- Mistreatment of Highmark employees and/or contractors.
- Deliberate or negligent omission or falsification of significant information on any company form.
- Sales of a product by any individual other than the licensed producer who presented the product and signed the enrollment form.
- Accepting any monetary or other rewards including, but not limited to, rewards for influencing the enrollee’s choice of physician, medical center, or pharmacy.
- Willful use (with intent to misrepresent) of marketing material(s) not provided by the company, and therefore not filed with and approved by CMS for use.
- Rebating or splitting commissions with another person who is not a licensed and contracted producer (i.e., payment of any kind or amount to a member or non-member as reimbursement for

Severe violation disciplinary procedures

- A severe violation committed by the agent will result in a notification to the agent and/or their general agency, as applicable, alerting them of the infraction. This notification will alert the agent and/or their general agency, as applicable, that they have been accused of a severe violation and that an investigation will be conducted.
- After the investigation is completed, if it is confirmed that the agent committed the infraction, immediate contract suspension, termination, and/or retraction of commissions may result.
- The results of each investigation will be reviewed by the Federal Markets Sales Department to determine the appropriate disciplinary action, at which point the agent will be notified of their contract status with Highmark.

Highmark will report any disciplinary action that results from an investigation of a complaint to CMS in accordance with the CMS Reporting Requirements. Disciplinary action taken could fall within a broad continuum, from manager coaching, documented verbal warning, retraining, a documented corrective action plan, suspension, commission retraction, or termination of employment or contract.

Highmark will report the termination of any agents and the reasons for the termination to the state in which the agent has been appointed in accordance with the state appointment law. Highmark will make the report available upon CMS’ request until further guidance has been issued regarding designated reporting dates to CMS.

In addition, Highmark will report incidences of submission of applications by unlicensed agents to the authority in the state where the application was submitted.

a referral name on the condition that the referred person purchases one of our products).

- Any marketing activity that is a violation of Highmark’s, CMS, or DOI regulations.
- Marketing or selling products for the following year prior to the CMS-determined Annual Enrollment Period (AEP) or Open Enrollment Period (OEP) marketing date.
- Marketing or selling products for a contract year prior to taking the annual Highmark-specific training on rules and regulations and passing the test with a score of at least 85%.

All About the BlueCard® Program

The Blue Cross Blue Shield Association’s BlueCard® Program connects independent Blue Plans across the country, with access to the largest physician and hospital networks in the U.S. and over 1.7 million providers, including 95% of all hospitals.* When members travel, they are covered in 190 countries through the Blue Cross Blue Shield Global® Core program.* BlueCard® allows in-network access to routine, urgent, and emergency care from BlueCard® participating providers.

However, certain services may still require members to work with their BlueCard® participating provider to obtain prior authorization. To determine if care requires prior authorization, the member can call Member Service at the number on the back of their ID card. The level of coverage depends on the chosen plan.

Under this program, many out-of-state facilities are in network due to our partnerships with them.

Note: The BlueCard® program applies to PPO plans for Medicare Advantage and all plans for Individual ACA except Together Blue EPO, where only emergency coverage is included.

The best way to find a BlueCard® facility is to call **800-810-BLUE** or visit the BlueCard® Doctor and National Hospital Finder website at **bcbs.com**.

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* According to the Blue Cross Blue Shield Association.

Highmark’s Medicare Advantage Star Ratings

The Centers for Medicare and Medicaid Services (CMS) created the Part C and D Star Ratings to provide quality and performance information to Medicare beneficiaries to assist them in choosing their health plan.

What do the Medicare Advantage Star Ratings really mean?

Each Medicare Advantage contract receives a single Star Rating from CMS annually. A contract is made up of one or more Product Benefit Plans (PBPs) or simply “plans.” Performance data for members enrolled in those plans are collectively used to calculate the contract’s overall Star Rating. The Star Rating associated with each plan represents the overall contract’s Star Rating.

Plans offering access to health services are scored on the quality of many different measures that fall into five categories:

- 1. Staying healthy: screenings, tests, and vaccines**
 - Includes whether members got various screening tests, vaccines, and other checkups that help them stay healthy.
- 2. Managing chronic (long-term) conditions**
 - Includes how often members with different conditions got certain tests and treatments that help them manage their condition.
- 3. Member experience with the health plan**
 - Includes ratings of member satisfaction with the plan.
- 4. Member complaints and changes in the health plan’s performance**
 - Includes how often Medicare found problems with the plan and how often members had problems with the plan.
 - Also includes how much the plan’s performance has improved (if at all) over time.
- 5. Health plan customer service**
 - Includes how well the plan handles member appeals.

Plans offering prescription drug coverage are scored on the quality of many different measures that fall into three categories:

- 1. Member complaints and changes in the drug plan’s performance**
 - Includes how often Medicare found problems with the plan and how often members had problems with the plan.
 - Also includes how much the plan’s performance has improved (if at all) over time.
- 2. Member experience with the drug plan**
 - Includes ratings of Member Satisfaction with the plan.
- 3. Drug safety and accuracy of drug pricing**
 - Includes how accurate the plan’s pricing information is and how often members with certain medical conditions are prescribed drugs in a way that is safer and clinically recommended for their condition.

Why do Star Ratings matter?

- Achieving strong Star Ratings helps Highmark sustain choice and affordability for Medicare-eligible customers in our service area.
- Our Star Ratings performance reflects our commitment and ongoing investment in improving the health care experience for our members.
- The financial benefit of favorable Star Ratings will also help us keep a strong and consistent option for Medicare Advantage customers.
- Plans that achieve a rating of five stars are considered to be the top quality performers in serving Medicare beneficiaries. Beneficiaries are able to switch into a five-star plan at any time throughout the year, once per calendar year.
- Low-performing plans (below three stars) are at risk of having enrollment blocked by the federal government or being removed entirely from the Medicare program.

Lagging timeline

Star Ratings are not on the typical one-year planning cycle, where what we do this year impacts next year. Instead, the annual Star Ratings reflect performance from two years prior.

How can you positively impact Star Ratings?

You are the face of our plan and how you portray our plans and interact with your clients can positively affect our Star Ratings. Your professionalism and accuracy are very important to some of the performance categories measured by CMS, especially for the Member Satisfaction category. You can positively impact Star Ratings by being accurate when you present a plan and by encouraging members to use their benefits, complete an annual wellness visit, seek appropriate care, complete preventive screening and tests, and adhere to their medications. You must be able to:

- Know the benefits you are selling, accurately explain the plan, and determine the best fit for the consumer. This supports the consumer with their plan selection, strengthens your relationship, and may also help avoid complaints.
- Encourage consumers and members to use their benefits because Star Ratings are influenced by whether or not our members obtain specific services, such as: receiving annual screenings and preventive care, visiting their primary care physician (PCP), and properly using their medications (referred to as “medication adherence”).
- Reduce the chance that any type of complaint would be filed by doing what is required in all sales presentations and appointments and lending proper support to your consumers.
- Earn high scores on your sales events if you are secret-shopped by mentioning all required statements and showing consumers all required materials. One of the things you are required to cover is information on Star Ratings.

Enrollment Processes

Before completing an enrollment application with a beneficiary, you must confirm that the prospect is eligible, i.e., entitled to Medicare Part A and Part B benefits as of the effective date of coverage under the plan.

Examples of acceptable proof of eligibility include:

- A copy of a Medicare card.
- A copy of a Medicaid award letter for dual-eligible Special Needs Plans.
- A Social Security Administration award notice.
- A Railroad Retirement Board letter of verification.
- A statement from the Social Security Administration or Railroad Retirement Board verifying the consumer’s Medicare eligibility.

When you make a presentation to any prospect, be sure to use only a current Highmark CMS-approved sales presentation to ensure you’ve covered all required information.

Once you have completed the application, you may submit it to Highmark via the following methods:

1. Online through the Highmark Producer Portal – producer.highmark.com
2. Phone Number: **866-673-9112**
Once you have completed a phone consultation with the prospect and the prospect is ready to complete the enrollment, you may conference call our dedicated enrollment line for the beneficiary to complete the enrollment telephonically. (The personnel staffing the enrollment line are unlicensed agents and will not be able to provide consultative assistance to you or the beneficiary. If the beneficiary has any plan-specific questions, they will be directed to call their licensed agent back to assist before completing the enrollment.)

Required information: Please provide the unlicensed enrollment agent with your name and NPN, the beneficiary’s name, and the plan they wish to enroll in. The unlicensed enrollment agent staffing the line will then process the enrollment telephonically. To ensure all applications are properly processed, you must send the beneficiary’s name, DOB, and the selected plan to highmarkseniormarkets@highmark.com.

What happens next?

If the enrollment application is complete, Highmark will submit the completed enrollment application to the Centers for Medicare and Medicaid Services (CMS). CMS will determine approval for requested coverage.

Once the enrollment application is approved by CMS, the member will receive:

- An enrollment verification letter.
- A welcome kit (mailed within seven days of CMS acceptance).
- An ID card (mailed within 10 days of CMS acceptance).

If the enrollment application is denied, the member will receive a denial letter with the reason for denial. This is mailed within 10 days of the application denial.

If the enrollment application is incomplete, Highmark will reach out to the member and/or agent by phone and/or written communication to obtain the missing information. If the missing information is received within 21 days, or the end of the current month (whichever is later), the enrollment application will be submitted to CMS. CMS will determine approval for the requested coverage. If the missing information is not received in time, the application will be denied.

Part B and D IRMAA

What is the Part B and Part D Income-Related Monthly Adjusted Amount (IRMAA)?

If your client or prospective client has a higher income, the law requires an adjustment to their monthly premiums for Medicare Part B (medical insurance) and Medicare Part D (prescription drug coverage). This adjustment is known as the Income-Related Monthly Adjustment Amount (IRMAA). IRMAA is paid directly to Medicare. It is not part of the plan premium. Your client will be notified by Social Security if IRMAA is applicable. The following table is the most current information available as of the date of publication of this guide. Please note that the standard premium for 2025 is \$185.

File individual tax return*	File joint tax return*	File married and separate tax return*	Part B Monthly Premium Increase	Part D Monthly Premium Increase
\$106,000 or less	\$212,000 or less	\$106,000 or less	\$0.00	Plan premium
Above \$106,000 up to \$133,000	Above \$212,000 up to \$266,000	Not Applicable	\$74.00	\$13.70
Above \$133,000 up to \$167,000	Above \$266,000 up to \$334,000	Not Applicable	\$185.00	\$35.30
Above \$167,000 up to \$200,000	Above \$334,000 up to \$400,000	Not Applicable	\$295.90	\$57.00
Above \$200,000 up to \$500,000	Above \$400,000 up to \$750,000	Above \$106,000 up to \$394,000	\$406.90	\$78.60
\$500,000 and above	\$750,000 and above	\$394,000 and above	\$443.90	\$85.80

*Based on 2023 filing for 2025 calendar year.

Election Periods

Medicare Advantage and Part D election periods

Initial Election Period (IEP) is the period during which an individual may make an initial election to enroll in an MA plan.

Annual Election Period (AEP) is the period when an individual may enroll or disenroll from an MA plan.

Open Enrollment Period (OEP) is a time frame that allows an individual enrolled in a Medicare Advantage plan* a one-time opportunity to:

- Switch to a different Medicare Advantage plan.
- Drop their Medicare Advantage plan and return to Original Medicare, Part A and Part B.
- Sign up for a stand-alone Medicare Part D Prescription Drug plan (if they return to Original Medicare).

Special Election Period (SEP) is a time frame that allows some individuals to enroll in an MA plan outside of the IEP and AEP if they meet certain requirements. A few examples are people who are eligible for extra help in paying for their Medicare prescription, such as if they qualify for Low-Income Subsidy (LIS) or Programs of All-Inclusive Care for the Elderly (PACE), or people who have lost their employer group coverage or relocated outside the plan’s service area.

	Part C (Medicare Advantage plans)	Part D (Prescription Drug plans)	Plans Available		
			MA/MA-PD	PDP	Medigap
IEP	Once per lifetime	Starts 3 months before and ends 3 months after month of eligibility — total 7 months	X	X	X
AEP	Oct. 15 to Dec. 7	Oct. 15 to Dec. 7	X	X	X
OEP*	Jan. 1 to March 31	N/A	X	X	X
SEP	All year	All year	X	X	X
5-Star SEP	Dec. 8 to Nov. 30	Dec. 8 to Nov. 30	X	X	

*Individuals enrolled in Original Medicare, a cost plan, or other plan types are not eligible to use OEP to enroll in an MA plan. Individuals enrolled in a Part D only plan are not eligible to make changes during OEP.

PACE and PACENET

What is PACE/PACENET coverage?

The Pharmaceutical Assistance Contract for the Elderly (PACE) program is a lottery-funded program that provides prescription drug coverage to Pennsylvania residents, ages 65 and older, who meet the program’s income requirements:

	Single Income Limit	Married Income Limit	Copay Generic	Copay Single-Source Brand
PACE	\$14,500	\$17,700	\$6	\$9
PACENET	\$14,501 – \$33,500	\$17,701 – \$41,500	\$8	\$15

PACE/PACENET FAQs

Q: If I am enrolled in a Highmark Part D plan, will I still use my PACE or PACENET card?

Yes, show both cards at the pharmacy. This will let your pharmacist know to bill Highmark first and bill PACE or PACENET second. It will also let your pharmacist know that you are entitled to all of the drugs that are available under PACE and PACENET.

Q: Will my copayments be higher with PACE/PACENET and Highmark Part D plan?

No, not for medications that are covered by PACE/PACENET. If your Highmark plan charges higher copayments than you were paying under PACE/PACENET, the program will pay the difference if the pharmacy has the capability to bill more than one payer for a prescription claim. If you are taking medications that are not covered by PACE/PACENET, you will pay the Highmark plan’s copay for those drugs. If you run into any confusion at the pharmacy, call the program’s toll-free number at **800-225-7223** while you’re still at the pharmacy.

Q: What happens if my Highmark plan charges lower copayments than PACE/PACENET?

You will pay the lower copayments when the Part D plan pays for medication.

Q: What happens if my Highmark Part D plan doesn’t cover all of the drugs that PACE/PACENET covers?

If your Part D plan has a restrictive drug formulary, PACE/PACENET will cover your prescription medications or work directly with the plan to process a prior authorization on your behalf so the drugs will be covered by your Part D plan.

Q: Can I go to any pharmacy I choose if I am in PACE and Medicare Part D?

No. You must use the pharmacies that are in your Highmark Part D plan’s network. If you decide to change pharmacies, check with your new pharmacy to make sure they participate in your Highmark Part D plan and PACE.

Q: If my Part D plan offers a mail-order service, can I use it?

Yes. However, the mail order pharmacy must participate with the PACE Program in order for the program to help pay for your extra copayments. Please have your doctors verify if the mail order pharmacy is in the PACE network prior to submitting prescriptions for processing. Also, when you receive a three-month supply of your drug(s) by mail, you will pay up to three PACE/PACENET copayments at once. For example, a PACE cardholder would pay up to \$18 for a 90-day supply of generic medications.

New York EPIC Program

The Elderly Pharmaceutical Insurance Coverage (EPIC) program is a New York State program for seniors administered by the Department of Health. It helps more than 325,000 income-eligible seniors aged 65 and older to supplement their out-of-pocket Medicare Part D drug plan costs. Seniors can apply for EPIC at any time of the year and must be enrolled or eligible to be enrolled in a Medicare Part D drug plan to receive EPIC benefits and maintain coverage.

EPIC provides secondary coverage for Medicare Part D and EPIC-covered drugs purchased after any Medicare Part D deductible is met. EPIC also covers approved Part D-excluded drugs once a member is enrolled in Part D.

To join EPIC, a senior must:

- Be a New York State resident age 65 or older.
- Have an annual income below \$75,000 if single or \$100,000 if married.
- Be enrolled or eligible to be enrolled in a Medicare Part D plan (no exceptions), and not be receiving full Medicaid benefits.

Note: You can join EPIC at any time during the year. Once enrolled, you will receive a ‘Special Enrollment Period’ to join a Medicare Part D drug plan. You are not eligible to receive EPIC benefits until you are enrolled in a Part D drug plan.

Seniors who are not eligible to join a Medicare Part D drug plan cannot join EPIC (e.g., seniors with a union/retiree drug subsidy program that is not a Part D plan, seniors without Medicare Part A or Medicare Part B).

Seniors with Medicare Advantage (HMO) health insurance can only join EPIC if they have Part D drug coverage with their HMO.

Residency

To enroll in EPIC, a beneficiary must be a resident of New York State. This means that their permanent home (not a summer or winter home) is located in New York State. It also means they live in the State on a regular, ongoing basis, and their New York State address is listed as their home address on official and legal documents. They need to notify EPIC whenever they change their address.

Income

For purposes of an EPIC enrollment, household gross income is the previous year’s total annual income of the senior or married spouses. It includes, but is not limited to:

- Federal adjusted gross household income as reported on your income tax return.
- Social Security payments (less Medicare premiums).
- Railroad retirement benefits.
- The taxable amount of IRA distributions and retirement annuities.
- Support money, including foster care support payments.
- Supplemental Security income.
- Tax-exempt interest.
- Worker’s compensation.
- Gross amount of loss-of-time insurance.
- Cash public assistance and relief, other than medical assistance for the needy.
- Nontaxable strike benefits.
- Veterans’ disability pensions.
- Lottery winnings.

It does not include:

- Food stamps.
- Medicare premiums.
- Medicaid.
- Scholarships.
- Grants.
- Surplus food.
- Payments made to veterans under the federal Veterans’ Dioxin and Radiation Exposure Compensations Standards Act (Agent Orange).
- Payments made to individuals because of their status as victims of Nazi persecution.

Low-Income Subsidy (LIS)

The Low-Income Subsidy (LIS) helps people with Medicare pay for prescription drugs, and lowers the costs of Medicare prescription drug coverage.

The resource limits used to determine eligibility for the LIS are as follows:

Marital Status	2025 LIS Resource Limit with Burial Expenses
Single	\$17,600
Married	\$35,130

The maximum LIS beneficiary cost-sharing table is as follows:

Low-Income Subsidy Category	Deductible	Copayment up to Out-of-Pocket Threshold	
		Generic	Brand
Full-Benefit Dual Eligible Beneficiaries Institutionalized or Receiving Home- and Community-Based Services	\$0	\$0	\$0
Full-Benefit Dual Eligible Beneficiaries with income ≤ 100% FPL	\$0	\$1.60	\$4.80
Full-Benefit Dual Eligible Beneficiaries with income between 100% and 150% FPL	\$0	\$4.90	\$12.15
Non-Full Benefit Dual Eligible Beneficiaries Applied or are eligible for Medicare Savings Program (QMB-only, SLMB-only, or QI); or Supplemental Security Income (but not Medicaid)	\$0	\$4.90	\$12.15
Non-Full Benefit Dual Eligible Beneficiaries Applied and with income ≤ 150% FPL for 2024 and resources ≤ \$17,600 (\$35,130 if married)	\$0	\$4.90	\$12.15

Frequently Asked Questions

Q: How do I locate a provider within the Blue Card network?

For PPO members visiting a county or state outside of their current plan coverage area, they can locate providers by following these steps:

1. Visit [provider.bcbs.com](#).
2. Enter a ZIP code.
3. Select **Browse a List of Plans**.
4. Choose **Medicare Advantage PPO** and scroll down to choose the appropriate Highmark home plan.

Q: What is the claim submission process when utilizing a provider through the BlueCard® network?

Participating providers should submit claims to their local Blue Plan.

Q: How am I billed for Emergency Care Worldwide?

When outside of the United States, members should expect to pay upfront; however, they can then submit an itemized receipt for reimbursement, less their Emergency Care copay.

Q: What happens to my total drug spend if I switch plans throughout the year?

Their drug spend will only reset Jan. 1 of each year. It does not reset when changing plans.

Q: How is transportation covered?

Transportation coverage varies by plan. Some plans cover a one-way trip home after an ER discharge and related follow-up doctor visits; the servicing provider arranges transport. Other plans offer a set number of one-way trips for non-emergency medical appointments (doctor, pharmacy, etc.); a copay may apply, and the transportation provider makes arrangements. Destination must be plan-approved. See the Product Guide’s benefit grids for plan-specific details.

Q: Where can I go to pay the lowest amount for lab work?

To a participating freestanding lab such as Quest Diagnostics and Labcorp. Please check the provider search tool to verify available freestanding labs. Labs at a hospital or affiliated with a hospital will not process with the lowest cost share.

Q: How do I utilize the OTC benefit? Am I automatically sent a catalog?

You may redeem your OTC benefits by visiting the online store at [shophighmarkotc.com](#). Physical catalogs are available on request from Member Service.

Q: Does an unused OTC benefit amount carry over to the next quarter?

OTC benefits must be used within the calendar quarter, or they will be forfeited. Conversely, any amount spent above the benefit allowance per quarter will be the responsibility of the member.

Frequently Asked Questions, cont.

Q: Is shipping covered with my OTC benefit?

Shipping is free for the first order per quarter. All subsequent orders will incur a shipping charge at the member’s expense.

Q: How can I reach TruHearing to utilize benefits?

Contact TruHearing directly at **855-544-7171** (or 800-334-1807, TTY: 711) to locate a provider and schedule an appointment.

Q: Where can I find a list of participating vision providers?

Optometrists for routine vision can be found by visiting **davisvision.com**.

1. Select **Find an eye care professional** from the banner at the top of the homepage.
2. From there you will be able to search by location and/or the provider’s name or business name.

Q: Where can I find a list of participating dental providers?

Routine dental providers can be found by visiting **unitedconcordia.com**.

1. Select **Find a Dentist** at the top right corner of the homepage.
2. Choose your location.
3. Select your network: National Medicare Advantage Dental. (This is the same for all of our MAPD plans that include dental, as well as the Whole Health Balance option offered to Medigap members.)

Q: Why am I still receiving invoices despite signing up for Electronic Funds Transfer (EFT)?

EFT takes approximately 45 – 60 days to be set up. Timing can be impacted by queue volume and response time from the member’s bank. In the meantime, you will need to continue paying invoices until they receive notice that EFT is starting deductions.

Q: A client would like me to be their Agent of Record (AOR). How do I request this change?

A change cannot be requested. If the agent submits a plan change, the AOR change will go through. Duplicate applications submitted for the active plan will not process as an AOR change.

Tips for Using the Online Provider Search Tool

Q: How do I locate the provider search tool?

medicare.highmark.com

At the bottom of the homepage, you will find useful links such as **Find a Provider** and **Find a Dentist**. The dental link will automatically link you to the National Medicare Advantage dental search. Please note, the vision link is for a medical specialist (ophthalmologist). If you are looking for a routine vision provider, please see **davisvision.com**.

Q: Why am I only finding one or a few of the providers from a practice and not the actual provider my client sees?

If you find the practice itself or other providers at that location, you can consider all providers at the practice/ location as participating.

Q: How do I find providers outside of the Highmark sales region?

provider.bcbs.com

Choose a location and a plan. From there, you will be asked for the alpha prefix. To bypass, select **Browse a list of plans**. For PA, you can use PA Highmark Blue Shield or PA Highmark Blue Cross Blue Shield. For WV, use WV Highmark Blue Cross Blue Shield. From there, you can search for providers available through our Travel Program.

Q: Why am I having trouble locating routine vision and dental providers?

An optometrist for routine vision can be found at **davisvision.com**. Routine dental providers can be found at **unitedconcordia.com**.

Q: What is the dental network?

All plans that include dental coverage (Whole Health Balance as well) use the National Medicare Advantage network through United Concordia.

Medical Underwriting Guidelines

Medigap Blue — Pennsylvania updated underwriting guidelines

Health questions to determine eligibility — Pennsylvania

Prior to approving an application for enrollment, Highmark reserves the right to review previous and current applications for coverage as well as claims history.

The following questions, if answered “yes,” will result in a member not being eligible for a Medigap Blue plan.

- Were you enrolled in Medicare prior to age 65 due to a disability?
- Are you now or have you been advised in the next year to be any of the following?
 - Admitted as an inpatient to a hospital
 - Confined to a nursing facility for other than short-term rehabilitation
 - Paralyzed, bedridden, or confined to a wheelchair
 - Receiving dialysis
- Within the past two years, have you been diagnosed or treated (including prescription drugs) for any of the following conditions? Do not include any genetic information, such as family medical history or any information related to genetic testing, services, or counseling.
 - Cancer (other than skin cancer), leukemia, lymphoma, melanoma
 - Heart, coronary, or carotid artery disease (not including high blood pressure), heart attack, aneurysm, congestive heart failure or any other type of heart failure, enlarged heart, stroke, transient ischemic attacks (TIA), or hemophilia
 - Bone marrow or other organ transplant
 - ALS (Lou Gehrig’s disease), multiple sclerosis (MS), Parkinson’s, systemic lupus erythematosus (SLE), Alzheimer’s, or dementia
 - AIDS, AIDS-related complex (ARC), or tested positive for HIV
 - Chronic renal disease such as ESRD
- Have you been advised to have a joint replacement in the next year, or have you received a joint replacement within the past six months?

Health questions to determine eligibility — Pennsylvania (cont.)

The following questions help determine rate.

If answer is “no” to the following questions, the application is approved at the preferred rate, unless the BMI is 40 or greater. If BMI is 40 or greater, the application is approved at the standard rate.

- Have you been diagnosed, received treatment (including prescription drugs), or had any of the following conditions?
 - **Heart conditions**
 - » Heart rhythm disorders
 - **Lung conditions**
 - » Chronic obstructive pulmonary disease (COPD)
 - » Emphysema
 - **Liver conditions**
 - » Cirrhosis of the liver
 - » Hepatitis C
 - **Diabetes**
 - » Type I or Type II
 - **Eye conditions**
 - » Macular degeneration
 - **Gastrointestinal conditions**
 - » Chronic pancreatitis
 - » Esophageal varices
 - » Ulcerative colitis
 - **Musculoskeletal conditions**
 - » Amputation due to disease
 - » Rheumatoid arthritis
 - » Spinal stenosis
 - » Degenerative disk or herniated disk
 - » Osteoporosis
- **Psychological/mental conditions**
 - » Bipolar or manic depressive
 - » Schizophrenia
- **Substance abuse**
 - » Alcohol abuse or alcoholism
 - » Drug abuse or use of illegal drugs
- Within the past two years, have you ever:
 - Been hospitalized or had inpatient surgery?
 - Smoked cigarettes or used any tobacco product?

If a “yes” answer is provided for any of these questions, the application is approved at the standard rate.

If a “yes” answer is provided for the tobacco question and there is one or more “yes” answers in these questions, the application is denied.

If applicant answers “no” to these questions, with exception of “yes” answer to the tobacco question and the applicant’s BMI is 40 or greater, the application is denied.

If all answers are “no” and the tobacco question is answered “yes” and the applicant’s BMI is less than 40, the application is approved at the standard rate.

Medical Underwriting Guidelines, cont.

Medigap Blue — West Virginia updated underwriting guidelines

Health questions to determine eligibility — West Virginia

Prior to approving an application for enrollment, Highmark reserves the right to review previous and current applications for coverage as well as claims history.

The following questions, if answered “yes,” will result in a member not being eligible for a Medigap Blue plan.

- Were you enrolled in Medicare prior to age 65 due to a disability?
- Are you now or have you been advised in the next year to be any of the following?
 - Admitted as an inpatient to a hospital
 - Confined to a nursing facility for other than short-term rehabilitation
 - Paralyzed, bedridden, or confined to a wheelchair
 - Receiving dialysis
- Within the past two years, have you been diagnosed or treated (including prescription drugs) for any of the following conditions? Do not include any genetic information, such as family medical history or any information related to genetic testing, services, or counseling.
 - Cancer (other than skin cancer), leukemia or lymphoma, melanoma
 - Heart, coronary, or carotid artery disease (not including high blood pressure), heart attack, aneurysm, congestive heart failure or any other type of heart failure, enlarged heart, stroke, transient ischemic attacks (TIA), hemophilia, or heart rhythm disorders
 - Diabetes
 - Chronic obstructive pulmonary disease (COPD), emphysema
 - Bone marrow or other organ transplant
 - ALS (Lou Gehrig’s disease), multiple sclerosis (MS), Parkinson’s, systemic lupus erythematosus (SLE), Alzheimer’s, or dementia
 - AIDS, AIDS-related complex (ARC), or tested positive for HIV

- Hepatitis C
- Chronic pancreatitis, esophageal varices, or ulcerative colitis
- Chronic renal disease such as ESRD
- Bipolar, manic depressive, schizophrenia, or psychological illness requiring hospitalization
- Have you been advised to have a joint replacement in the next year, or have you received a joint replacement within the past six months?

Responses to the following questions will be collected, but will not affect the outcome of the review.

- Have you been diagnosed, received treatment (including prescription drugs), or had any of the following conditions?
 - **Musculoskeletal conditions**
 - » Amputation due to disease
 - » Rheumatoid arthritis
 - » Spinal stenosis
 - » Degenerative disk or herniated disk
 - » Osteoporosis
 - **Liver conditions**
 - » Cirrhosis of the liver
 - **Eye conditions**
 - » Mascular degeneration
- Within the past two years, have you ever:
 - Been hospitalized or had inpatient surgery?
 - Smoked cigarettes or used any tobacco product?

If the applicant’s BMI is greater than 40, **the application is denied.**

Medigap Blue — Delaware underwriting guidelines

Health questions to determine eligibility — Delaware

Prior to approving an application for enrollment, Highmark reserves the right to review previous and current applications for coverage as well as claims history.

The following questions, if answered “yes,” will result in a member not being eligible for a Medigap Blue plan.

- Were you enrolled in Medicare prior to age 65 due to a disability?
- Are you now or have you been advised in the next year to be any of the following?
 - Admitted as an inpatient to a hospital
 - Confined to a nursing facility for other than short-term rehabilitation
 - Paralyzed, bedridden, or confined to a wheelchair
 - Receiving dialysis
- Within the past two years, have you been diagnosed or treated (including prescription drugs) for any of the following conditions? Do not include any genetic information, such as family medical history or any information related to genetic testing, services, or counseling.
 - Cancer (other than skin cancer), leukemia, lymphoma, melanoma
 - Heart, coronary, or carotid artery disease (not including high blood pressure), heart attack, aneurysm, congestive heart failure or any other type of heart failure, enlarged heart, stroke, transient ischemic attacks (TIA), or hemophilia
 - Diabetes (using insulin)
 - Bone marrow or other organ transplant
 - ALS (Lou Gehrig’s disease), multiple sclerosis (MS), Parkinson’s, systemic lupus erythematosus (SLE), Alzheimer’s, or dementia
 - AIDS, AIDS-related complex (ARC), or tested positive for HIV

- Chronic renal disease such as ESRD
- Cirrhosis of the liver, hepatitis C
- Chronic obstructive pulmonary disease (COPD), emphysema
- Alcohol abuse or alcoholism, drug abuse or use of illegal drug
- Bipolar or manic depressive, schizophrenia, psychological illness requiring hospitalization
- BMI greater than 40
- Have you been advised to have a joint replacement in the next year, or have you received a joint replacement within the past six months?

The following determines rate.

- If the answer to tobacco usage in the past 12 months is “yes,” a 25% surcharge will be added to the premium.

Responses to the following questions will be collected, but will not affect the outcome of the review.

- Have you been diagnosed, received treatment (including prescription drugs), or had any of the following conditions?

- Heart conditions	- Degenerative disc or herniated disc
- Heart rhythm disorders	- Osteoporosis
- Musculoskeletal conditions	- Gastrointestinal conditions
- Amputation due to disease	- Chronic pancreatitis
- Rheumatoid arthritis	- Esophageal varices
- Spinal stenosis	- Ulcerative colitis

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

☐ **Medicare Advantage Plans (Part C)**

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan’s network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

☐ **Medicare Supplement Plans (Medigap)**

Medicare Supplement (Medigap) Plan — A Medicare Supplement Insurance (Medigap) policy, sold by private companies, can help pay some of the health care costs that Original Medicare doesn’t cover, like copayments, coinsurance, and deductibles.

☐ **Medicare Special Needs Plans (HMO D-SNP)**

Medicare Special Needs Plan (HMO SNP) — For individuals entitled to Medicare Part A, enrolled in Medicare Part B, who live in the service area and receive Medicaid Assistance from the State.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, impact your current or future enrollment status or enroll you in a Medicare plan.

Beneficiary or authorized representative signature and signature date:

Signature: _____ Date: _____

If you are the authorized representative, please sign above and print below:

Representative’s name:_____

Your relationship to the beneficiary: _____

To be completed by Agent

Agent name:	Agent phone:
Beneficiary name:	Beneficiary phone:
Initial method of contact: (Indicate here if beneficiary was a walk-in)	
Agent’s signature:	
Plan(s) the agent represented during the meeting:	
Date appointment completed:	
[Plan use only:]	

**Scope of Appointment documentation is subject to CMS record retention requirements*

If the form was signed by the beneficiary at time of appointment, the Agent MUST provide an explanation why the SOA was not documented prior to meeting on the lines provided below:

Agent Sales Checklist

- ☐ Identify yourself as a Highmark licensed sales agent and have your name badge displayed.
- ☐ Confirm the Scope of Appointment was completed prior to the start of the meeting.
- ☐ Explain that in order to enroll in a Medicare Advantage plan, members must be enrolled in Medicare and continue to pay Part B premium.
- ☐ Describe Original Medicare and how it works when enrolled in a Medicare Advantage plan.
- ☐ Accurately describe the plans' deductibles, copays, coinsurance, OOP max.
- ☐ Accurately describe the copays and deductibles for drugs under Part D.
- ☐ Fully explain the cost of prescriptions during the coverage gap and catastrophic coverage period.
- ☐ Explain that certain prescription drugs have restrictions such as prior authorizations or quantity limits.
- ☐ Discuss the differences between MA and Medicare Supplement plans.
- ☐ Ensure the beneficiary(s) understood each plan(s) network and how they work.
- ☐ Explain how to locate a provider using the provider directory and/or provider website.
- ☐ Explain how to check if drugs are covered in the formulary.
- ☐ Review the Star Rating for all applicable plans.
- ☐ Describe the different enrollment periods including AEP, MAPD, and possible SEPs.
- ☐ Avoid making absolute statements.
- ☐ Avoid scare tactics.
- ☐ Avoid cross-selling of non-health products.
- ☐ Avoid using unapproved marketing material.

SECTION III

D-SNP

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Introduction

Highmark D-SNP plans are specialized Medicare Advantage Plans, which means the benefits are designed for people with special health care needs who have Medicare and are also entitled to assistance from Medicaid. Like all Medicare Advantage Plans, these D-SNP plans are approved by Medicare and have contracts with their State Medicaid programs to coordinate Medicaid benefits.

What is a Dual Eligible Special Needs Plan?

Members who are eligible for both Medicare and Medicaid (Medical Assistance from the State), can join a Dual Eligible Special Needs Plan (D-SNP). D-SNPs are approved by Medicare but are run by private companies.

Benefits of a D-SNP:

- Members get hospital, medical, and prescription drug coverage through one plan.
- Members have a large network of providers to choose from.
- All medically necessary and preventive services offered under parts A and B are covered, in addition to prescription drug coverage under Part D.
- Many plans offer value-added benefits, including hearing, dental, vision, healthy food cards, and more.

D-SNP enrollment periods

Initial Enrollment Period (IEP)

This is a seven-month period that starts three months before the month containing the member’s 65th birthday, and continues for three months after.

Special Enrollment Period (SEP)

A member may be eligible for a Special Enrollment Period if they have certain life changes, such as losing a job, moving to a new area, or a change in household size. Some of the events that can qualify a member to enroll in a D-SNP during the year include:

- Qualifying for Medicaid. If they already have Medicaid benefits, become eligible or if Medicaid status changes, they can enroll in a Special Needs Plan at any time.
- Nursing home residency. Whether they’re moving in, moving out, or are currently living in a nursing home, they can enroll in a Special Needs Plan for the first time, switch plans, or opt out of their current plan.
- Moving outside the service area. If they move outside the service area covered by their current Special Needs Plan and they want to switch to another plan, they can do it during the SEP. If they do not enroll in a different D-SNP, they are automatically returned to coverage through Original Medicare.
- Their current D-SNP leaves Medicare. If this happens, they can sign up for a different D-SNP.

Annual Enrollment Period (AEP)

Oct 15. – Dec. 7 — Members can switch plans as many times as they want during AEP. They have until Dec. 7 by 11:59 p.m. to make a final decision.

Products Overview

D-SNP Plan eligibility requirements

Highmark Wholecare (PA)		Highmark Blue Cross Blue Shield (DE)		Highmark Blue Cross Blue Shield (WV)
Highmark Wholecare Medicare Assured Diamond (HMO SNP)	Highmark Wholecare Medicare Assured Ruby (HMO SNP)	Highmark Health Options Duals (HMO SNP)	Highmark Health Options Duals Select (HMO SNP)	Highmark Health Options Duals (HMO SNP)
Live in service area	Live in service area	Live in service area	Live in service area	Live in service area
Entitled to Medicare Part A	Entitled to Medicare Part A	Entitled to Medicare Part A	Entitled to Medicare Part A	Entitled to Medicare Part A
Enrolled in Medicare Part B	Enrolled in Medicare Part B	Enrolled in Medicare Part B	Enrolled in Medicare Part B	Enrolled in Medicare Part B
Full Medicaid: QMB, QMB+, SLMB+, and FBDE	Partial Medicaid: SLMB, QI, and QMB	Full Medicaid: QMB+, SLMB+, and FBDE	Partial Medicaid: SLMB, QI, and QMB	Full Medicaid: QMB, QMB+, SLMB+, and FBDE

Eligibility descriptions

Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only)	These individuals are entitled to Medicare Part A, have income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid.
QMBs with full Medicaid (QMB+)	These individuals are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits.
Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only)	These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid.
SLMBs with full Medicaid (SLMB+)	These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not in exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits.
Qualified Disabled and Working Individuals (QDWIs)	These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid.

Enrollment Processes

Here’s a brief overview of how to submit applications, enroll members, and check eligibility with Highmark:

Applications can be submitted to Highmark online through the Highmark Producer Portal — producer.highmark.com.

Checklist for enrollment

Information you’ll need to enroll a member:

- Name
- Address
- Date of birth
- Social Security Number
- Medicaid and Medicare numbers
- List of current doctors and prescriptions

How to check eligibility

To check for eligibility of a prospective member or if you need an SOA, you can contact Agent Support over the phone at **888-871-0417** or by email at HWCBrokerSupport@highmark.com.

- Make sure you have a Permission to Contact (PTC)/ Scope of Appointment.
- Have the member’s name, address, and date of birth. If you’re calling Agent Support, you should also have their social security number (SSN) and Medicare Beneficiary Number (MBI), if possible.

DE D-SNP enrollment scenarios

- When a full dual beneficiary enrolls in a D-SNP plan, their Medicaid plan carrier automatically changes to match their Medicare carrier, creating an aligned status (example: Highmark D-SNP and Highmark Medicaid).
- Delaware Full Duals may change their D-SNP plan monthly because of HIDE aligned status; their Medicaid plan will change to match Medicare each time they switch.
- QMB beneficiaries are no longer allowed to be enrolled in Full Dual plans, they must shop for a Partial Plan or go to MA Direct Pay/FFS.

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

☐ Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

☐ Medicare Advantage Plans (Part C)

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan’s network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

☐ Medicare Supplement Plans (Medigap)

Medicare Supplement (Medigap) Plan — A Medicare Supplement Insurance (Medigap) policy, sold by private companies, can help pay some of the health care costs that Original Medicare doesn’t cover, like copayments, coinsurance, and deductibles.

☐ Medicare Special Needs Plans (HMO D-SNP)

Medicare Special Needs Plan (HMO SNP) — For individuals entitled to Medicare Part A, enrolled in Medicare Part B, who live in the service area and receive Medicaid Assistance from the State.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, impact your current or future enrollment status or enroll you in a Medicare plan.

Scope of Sales Appointment Confirmation Form (cont.)

Beneficiary or authorized representative signature and signature date:

Signature: _____ Date: _____

If you are the authorized representative, please sign above and print below:

Representative's name: _____

Your relationship to the beneficiary: _____

To be completed by Agent

Agent name:	Agent phone:
Beneficiary name:	Beneficiary phone:
Initial method of contact: (Indicate here if beneficiary was a walk-in)	
Agent's signature:	
Plan(s) the agent represented during the meeting:	
Date appointment completed:	
[Plan use only:]	

*Scope of Appointment documentation is subject to CMS record retention requirements
If the form was signed by the beneficiary at time of appointment, the Agent MUST provide an explanation why the SOA was not documented prior to meeting on the lines provided below:

Agent Sales Checklist

To enroll a new member, you need their:

- ☐ Name
- ☐ Address
- ☐ Date of birth
- ☐ Social Security Number
- ☐ Medicaid and Medicare numbers (if available)
- ☐ List of current doctors and prescriptions

How to check eligibility

To check a member's eligibility, you can either call Agent Support or use one of the programs mentioned below to do it yourself. Here's how:

1. Make sure you have a Permission to Contact (PTC)/Scope of Appointment.
2. Have the member's name, address, and date of birth handy. If you're calling Agent Support, you should also have their Social Security Number (SSN) and Medicare Beneficiary Number, if possible.
3. If the member already has a Medicare plan, you use their Medical Assistance Number, Eligibility Code, or SSN to look them up.
4. Sign into all programs (MARx, eCIS [PA], DMES [DE], MMIS [WV], Provider network tool, and Formulary tool) or call Agent Support. Use the member's information to find them in the programs, or provide their information to Agent Support.
5. Check for eligibility. Make sure you take notes and capture all information connected to the member.

SECTION IV

ACA Individual Market

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Enrollment Processes

For Plan Year 2026: Open Enrollment Period

Nov. 1 – Jan. 15 (DE, PA, WV)

Nov. 1 – Jan. 31 (NY)

Members who enroll by Dec. 15 will have a plan effective date of Jan. 1. Members who enroll in a plan between Dec. 16 and Jan. 15 will have a plan effective date of Feb. 1. In NY, members who enroll in a plan between Jan. 16 and Jan. 31 will have a plan effective date of March 1.

Financial assistance

There are two kinds of extra cost savings available for Affordable Care Act (ACA) enrollees.

Advanced Premium Tax Credits (APTC)

APTC may be applied, in advance, to lower payments each month for premiums at any level Marketplace plan except Catastrophic.

Cost-Sharing Reductions (CSR)

CSR will lower deductibles and out-of-pocket costs that a member may pay at the time of service for doctor visits, lab tests, drugs, and other covered services. These savings are only available with enrollment in a Marketplace Silver plan. These plans will have the term **Extra Savings** in the name.

Special Enrollment Period

Special Enrollment Periods can apply any time throughout the year. Outside the Open Enrollment Period, members may only change or enroll in coverage if they have a qualifying life event.

Examples include:

- Losing eligibility for employer-sponsored coverage due to job loss, reduction in hours, employer no longer offering benefits, or business closing.
- Expiration of COBRA coverage or non-calendar year policy.
- Losing pregnancy-related or medically necessary coverage under Medicaid.
- Losing eligibility for Medicaid or CHIP.
- Losing eligibility for Medicare.
- Having a baby.
- Getting married.

Deadline for application: The application, SEP form, and supporting documentation typically must be submitted within 60 days after coverage is lost. In some cases, but not all, the application may be submitted up to 60 days before the loss of coverage.

Effective date: In most cases, this may be the first day of the month immediately following the application, or the second month after the application, depending on the type of special enrollment and date of application.

Note: Voluntarily quitting other health insurance coverage, being terminated for not paying premiums, or losing health insurance coverage that does not qualify as minimum essential coverage are not considered a loss of qualifying coverage. A conversion or HIPAA plan may be a good option if your client's policy terms prior to end of month.

Once an application is approved, the member will receive:

- An enrollment confirmation email received the next business day after application confirmation.
- A payment confirmation email and SMS received the next business day after payment confirmation.
- Once a member locks in their coverage by making their initial payment, the member ID card will be issued.
- A welcome email or SMS received within the first 14 business days of enrollment.
- A welcome booklet received within the first 30 – 60 business days of enrollment.

Member eBill registration

The simplest way for your client to pay their bill is by registering for an eBill account. Once they make their first payment and it's received, they can set up automatic payments to ensure they never miss one.

Refer to page 13 for information on how to enroll and utilize eBill.

2026 Advanced Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSR)

Pennsylvania, West Virginia, and Delaware

Who needs coverage?*	What is the income for those covered under the health plan?				
	Eligible for Medicaid	Eligible for CSRs and APTCs			Eligible for APTCs
	Medicaid Eligible Range (138% FPL or less)	Extra Savings Silver Plans			Standard
		138 – 149%** CSR plans	150 – 199% CSR plans	200 – 249% CSR plans	
Single	Less than \$21,597	\$21,598 – \$23,474	\$23,475 – \$31,299	\$31,300 – \$39,124	\$39,125 – \$62,600
Family of 2	Less than \$29,187	\$29,188 – \$31,724	\$31,725 – \$42,299	\$42,300 – \$52,874	\$52,875 – \$84,600
Family of 3	Less than \$36,777	\$36,778 – \$39,974	\$39,975 – \$53,299	\$53,300 – \$66,624	\$66,625 – \$106,600
Family of 4	Less than \$44,367	\$44,368 – \$48,224	\$48,225 – \$64,299	\$64,300 – \$80,374	\$80,375 – \$128,600
Family of 5	Less than \$51,957	\$51,958 – \$56,474	\$56,475 – \$75,299	\$75,300 – \$94,124	\$94,125 – \$150,600
Family of 6	Less than \$59,547	\$59,548 – \$64,724	\$64,725 – \$86,299	\$86,300 – \$107,874	\$107,875 – \$172,600
Family of 7	Less than \$67,137	\$67,138 – \$72,974	\$72,975 – \$97,299	\$97,300 – \$121,624	\$121,625 – \$194,600
Family of 8	Less than \$74,727	\$74,728 – \$81,224	\$81,225 – \$108,299	\$108,300 – \$135,374	\$135,375 – \$216,600

* +\$5,500 for each person over 8
** Income below 138% FPL: If your income is below 138% FPL and your state has expanded Medicaid coverage, you qualify for Medicaid based only on your income.

New York

Who needs coverage?*	What is the income for those covered under the health plan?			
	Eligible for Medicaid	Eligible for Essential Plan	Eligible for CSRs and APTCs	
	Medicaid Eligible Range (138% FPL or less)	Essential Plan	CSR 87%	CSR 73%
		138 – 250%**	251% – 350%	351% – 400%
Single	Less than \$21,597	\$21,598 – \$39,125	\$39,126 – \$54,775	\$54,776 – \$62,600
Family of 2	Less than \$29,187	\$29,188 – \$52,875	\$52,876 – \$74,025	\$74,026 – \$84,600
Family of 3	Less than \$36,777	\$36,778 – \$66,625	\$66,626 – \$93,275	\$93,276 – \$106,600
Family of 4	Less than \$44,367	\$44,368 – \$80,375	\$80,376 – \$112,525	\$112,526 – \$128,600
Family of 5	Less than \$51,957	\$51,958 – \$94,125	\$94,126 – \$131,775	\$131,776 – \$150,600
Family of 6	Less than \$59,547	\$59,548 – \$107,875	\$107,876 – \$151,025	\$151,026 – \$172,600
Family of 7	Less than \$67,137	\$67,138 – \$121,625	\$121,626 – \$170,275	\$170,276 – \$194,600
Family of 8	Less than \$74,727	\$74,728 – \$135,375	\$135,376 – \$189,525	\$189,526 – \$216,600

* +\$5,500 for each person over 8
** If you are below 250% FPL and not eligible for the Essential Plan you may be eligible for CSR products and APTCs.

APTC and CSR amounts are subject to change annually. Updates will be communicated as they are received.

APTCs and CSRs, cont.

Contribution and Out-of-Pocket Limits for QHDHPs and HSAs			
	2026	2025	Change
HSA contribution limit (employer + employee)	Self-only: \$4,400	Self-only: \$4,300	Self-only: +\$100
	Family: \$8,750	Family: \$8,550	Family: +\$200

At age 55, individuals can contribute an additional \$1,000.

* For more information, visit highmarkspendingaccounts.com.

The Department of Health and Human Services (HHS) establishes the annual out-of-pocket limits for essential health benefits covered under an ACA-compliant plan.

Take a look at these limits below:

	2026	2025
Out-of-pocket limits for ACA-compliant plans (HHS)	Self-only: \$10,600	Self-only: \$9,200
	Family: \$21,200	Family: \$18,400

Special Enrollment Period (SEP) Reminders

SEP forms and applications

Off-exchange SEP forms and applications are now electronically fillable and contain a digital signature option. You can download these materials on producer.highmark.com, under the **Resources** section as separate documents. Completed applications can be submitted via the following methods:

PA, DE, and WV:

- Email: dp_applications@highmark.com (one application per email)
- Fax: **866-224-5403**
- Mail: Use the address on the application

NY:

- Email: ACAEBNY@higmarkhealth.org (one application per email)
- Mail: Use the address on the application

Loss of minimal essential coverage

Examples include:

- Losing eligibility for employer-sponsored coverage due to job loss, reduction in hours, employer no longer offering benefits, or closing.
- Expiration of COBRA coverage or non-calendar year policy.
- Losing pregnancy-related or medically needy coverage under Medicaid.
- Losing eligibility for Medicaid or CHIP.
- Losing eligibility for Medicare.

Did you know...

Highmark pays commission on SEP enrollments for new contracts and renewals! To confirm your available commission amount, please contact the agency you write individual policies through.

Deadline: Application, SEP form, and documentation can generally be submitted up to 60 days in advance of the loss of coverage, but no later than 60 days since coverage was lost.

Effective date: In most cases, this may be the first day of the month immediately following the application, or the second month after the application, depending on the type of special enrollment and date of application.

Note: Voluntarily quitting other health insurance coverage, being terminated for not paying premiums, or losing health insurance coverage that does not qualify as minimum essential coverage are not considered a loss of qualifying coverage. A conversion or HIPAA plan may be a good option if your client's policy terms prior to end of month.

A conversion or HIPAA plan may be a good option if your client's policy terms prior to end of month.

Please refer to the Off-Exchange Application for more detail.

Agent Sales Checklist

Here’s the info needed for each person who will be covered on a plan.

- ☐ Date of birth
- ☐ Social Security Number
(or legal immigration documents)
- ☐ Income documentation for all household members,
even if they won’t be covered by the plan
(pay stubs, W-2 forms, or wage and tax statements)
- ☐ Current health insurance policy numbers (if applicable)
- ☐ Info on any health insurance a consumer
or their family could get from their job

Individual Coverage Health Reimbursement Arrangement (ICHRA)

Individual Coverage Health Reimbursement Arrangement (ICHRA)

ICHRA overview

Background

In June 2019, the Departments of the Treasury, Labor, and Health & Human Services jointly published a final rule to expand the flexibility and use of health reimbursement arrangements (HRAs) and other account-based group health plans to provide Americans with additional options to obtain quality, affordable health care.

This rule permits employers to offer an “individual coverage HRA” (ICHRA) as an alternative to traditional group health plan coverage, subject to certain conditions. Among other medical care expenses, ICHRAs can be used to pay premiums for individual health insurance chosen by the employee, promoting employee and employer flexibility, while also maintaining the same tax-favored status for employer contributions toward a traditional group health plan.

Things to keep in mind

- An ICHRA is not traditional group coverage — it is Individual coverage reimbursed by the employer group.
- Employers are required to provide the employee with an ICHRA Notice that establishes the 60-day SEP enrollment opportunity for the employee.
- Employees and any covered dependents are required to be enrolled in Individual coverage or Medicare Parts A and B, or Part C in order to be reimbursed.
- Employees cannot be given an option between an ICHRA and group coverage.
- Policies may be purchased through the Marketplace (not eligible for APTC or CSR) or Off-Exchange.

ICHRA/QSEHRA application processes

Here are some important dates to keep in mind throughout the application process:

- Allow 14 days from the date of submission for the application to process and bill account information to populate.
- Applications can be submitted up to 11:59pm on the last day of the month for effectuation of the first of the following month.
- Applications submitted after the requested effectuation date will result in effectuation of the first of the following month.

Tools for navigating enrollment

Producer Portal

OEP — Please visit page 4 for an overview and instructions for utilizing this tool during the ACA Open Enrollment Period.

SEP — Outside of the Open Enrollment Period, the Producer Portal is now a helpful resource for submitting ICHRA/QSEHRA SEP applications. Please keep in mind the following when utilizing this solution:

- This Producer Portal SEP process is **only available for ICHRA/QSEHRA** applications and requires upload of supporting documentation (SEP Form and ICHRA Employer Notice) in order to complete each submission.

Bulk enrollment

For more information on the availability of a bulk enrollment process, please contact the ICHRA team at ichra@highmark.com.

Paper application (OEP/SEP)

Producer Managed eBill Payment Administration (Broker, Third Party Administrator, etc.): Submit one application per contract per email (including SEP Form and ICHRA Notice when applicable) to the following addresses:

To: dp_applications@highmark.com
Cc: ichra@highmark.com

Employee/Member Managed Payment Administration: Submit one application per contract per email (including SEP Form and ICHRA Notice when applicable):

To: dp_applications@highmark.com

ICHRA Toolkit

The ICHRA Toolkit is a comprehensive resource that provides overview to ICHRA-specific processes. Reach out to the ICHRA team for access.

ICHRA contact information

- General ICHRA Inquiries, eBill Onboarding Requests, Producer eBill Support: ichra@highmark.com
- Producer Enrollment and Billing Inquiries: federalproducer@highmark.com
- ACA Producer Needs: acasalessupport@highmark.com
- ACA Commission Inquiries: acacompensation@highmark.com

Appendix

Contact Information

Question	Market	Region	Contact
Broker Managers	Medicare, ACA, D-SNP	Pennsylvania — Northwest and New York	Evan Cominsky Email: evan.cominsky@highmark.com Phone: 716-658-8653
		Pennsylvania — West Central	Kayla Bracken Email: kayla.bracken@highmark.com Phone: 814-691-0303
		Pennsylvania — Western	Bill Glas Email: william.glas@highmark.com Phone: 412-544-0741
		Pennsylvania — Central	Nicole Sherlock Email: nicole.sherlock@highmark.com Phone: 717-348-3269
		Pennsylvania — Northeast	Morgan Graybill Email: morgan.catherman@highmark.com Phone: 570-259-4817
		Delaware and Pennsylvania — Southeast (Philadelphia Market)	Felicia Anderson Email: felicia.anderson@highmark.com Phone: 302-559-6640
		West Virginia	Stephanie Stanley Email: stephanie.stanley@highmark.com Phone: 304-424-0377
Application Status, Benefits, Claims, Prescriptions, and Provider Network Questions	Medicare	PA, WV, DE	Phone: 800-652-9459 (M – F, 8 a.m. – 4 p.m.) Option 1 (Senior Markets), then Option 1 Email: federalproducer@highmark.com
		WNY, NENY	Phone: 844-946-6305 (M – F, 8 a.m. – 4 p.m.) Option 1 (Senior Markets), then Option 1 Email: albany.liaison@bsneny.com
	ACA	PA, WV, DE	Phone: 800-652-9459 (M – F, 8 a.m. – 4 p.m.) Option 2 (ACA), then Option 1 Email: federalproducer@highmark.com
		WNY, NENY	Phone: 844-946-6305 (M – F, 8 a.m. – 4 p.m.) Option 2 (ACA), then Option 1 Email: federalproducer@highmark.com
	D-SNP	PA	Phone: 888-871-0417 Email: hwcbrokersupport@highmark.com

Question	Market	Region	Contact
Onboarding, Annual Certification, and Producer Portal Questions	Medicare	PA, WV, DE, WNY, NENY	Phone: 800-652-9459 (M – F, 8 a.m. – 4 p.m.) Option 1 (Senior Markets), then Option 2 Email: highmarkseniormarkets@highmark.com
	ACA	PA, WV, DE, WNY, NENY	Phone: 800-652-9459 (M – F, 8 a.m. – 4 p.m.) Option 2 (ACA), then Option 2 Email: acasalessupport@highmark.com
	D-SNP	PA	Phone: 888-871-0417 Email: hwcbrokersupport@highmark.com
Additional Highmark Wholecare Resources	D-SNP	PA	Customer Service: 800-685-5209 D-SNP Website: highmarkwholecare.com/medicare
Highmark Producer Portal	Medicare, ACA	PA, WV, DE, WNY, NENY	producer.highmark.com
Highmark Consumer Websites	Medicare, ACA	PA, WV, DE, WNY, NENY	myhighmark.com
	D-SNP	PA	highmarkwholecare.com/medicare
Highmark Integrity Office	Medicare, ACA, D-SNP	PA, WV, DE, WNY, NENY	Phone: 800-985-1056 Email: integrity@highmark.com
PA Exchange (Pennie)	ACA	PA	Website: pennie.com Pennie Broker Contact Center: 844-844-4440 Email: brokers@pennie.com
DE/WV Exchange	ACA	WV, DE	Website: healthcare.gov Marketplace Broker Call Center: 855-788-6275
New York Exchange	ACA	WNY, NENY	Website: nystateofhealth.ny.gov
HealthSherpa	ACA	PA, WV, DE, WNY, NENY	Broker Support: 888-684-1373 Email: agent_support@healthsherpa.com

Glossary

Agent Field Guide	A confidential and proprietary document developed exclusively for Highmark Field Agents.
Applicable Law	Means any local, state, and federal laws, statutes, regulations, rules, codes, ordinances, orders, decisions, licensing requirement, regulatory guidance, pronouncements, and instructions, declarations, decrees, directives, legislative enactments, other binding restrictions or requirements of or by any governmental authority, any interpretation of any of the foregoing by a governmental authority having jurisdiction or authority or any modified or supplemented version of the foregoing items, which applies to or affects the services provided or the other obligations of the parties hereunder. “Applicable Law” includes but is not limited to HIPAA, the regulations, guidance, and instructions issued by CMS (including but not limited to the MMG), the Medicare Improvement for Patients and Providers Act, the False Claims Act (31 U.S.C. §§ 3729 et seq.), the anti-kickback statute (42 U.S.C. § 1320a-7b(b), Section 1557 of the Patient Protection and Affordable Care Act, TCPA and state and federal laws applicable to telemarketing, and laws or regulations applicable to insurers, agents, and brokers.
BPM	Broad Performance Medicare Network
CMS	The Centers for Medicare and Medicaid Services. The federal agency who administers the Medicare Program.
EPO	Exclusive Provider Organization

Highmark	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.
HMO	Health Maintenance Organization
Medicare	Health insurance provided by the U.S. government for people over 65, or for some disabled persons.
MPVN	Medicare Preferred Value Network
PDP	Prescription Drug Plan (Part D)
PPO	Preferred Provider Organization
Producer Portal	The website you will use to enroll Medicare clients online, check the status of applications, order customized enrollment kits, request CMS-approved marketing materials, view and download important documents, and view the most recent version of this Field Guide.
Ready to Sell	Trained, passed a background check, not on any exclusion lists, have an active state license, and have been appointed by Highmark to sell our products.

Enrollment/Disenrollment Member Responsibilities Quick Reference

Disenroll FROM	Enroll INTO	Member Responsibility
Medicare Advantage	Medicare Supplement	- Member must have a valid election to disenroll from Medicare Advantage and must submit a disenrollment request, in writing, with a valid signature to their Medicare Advantage Plan in order to disenroll. - If the member is requesting to cancel their MA Plan before the effective date, a written request can be submitted OR a verbal request can be taken on a recorded line with Member Service. Member can then be enrolled in Medigap once Proof of Prior Creditable Coverage documentation received. - If their MA Plan was also with Highmark and they now want to enroll in a Highmark Medigap Plan, a proof of prior coverage letter is not required, but we cannot move forward with a Medigap enrollment without an approved request to disenroll from their MA plan.
Medicare Advantage	Original Medicare	- Member must have a valid election to disenroll from Medicare Advantage and member must submit a disenrollment request, in writing, with a valid signature to the Medicare Advantage Plan in order to disenroll. - If attempting to cancel their MA Plan before the effective date, a written request can be submitted OR a verbal request can be taken on a recorded line with Member Service. Once disenrolled from Medicare Advantage, the member will automatically be re-enrolled into Original Medicare.
Medicare Supplement	Medicare Advantage	- Member must have a valid election to enroll into Medicare Advantage and application must be received by the plan PRIOR to the effective date. - Member must submit a disenrollment request, in writing, with a valid signature. - If attempting to cancel Med Sup before the effective date, a written request can be submitted OR a verbal request can be taken on a recorded line with Member Service.
Medicare Supplement	Original Medicare	- Member must submit a disenrollment request, in writing, with a valid signature in order to disenroll. - If the member is attempting to cancel their Med Sup before the effective date, a written request can be submitted OR a verbal request can be taken on a recorded line with Member Service; the member will then be placed back into Original Medicare.

Disenroll FROM	Enroll INTO	Member Responsibility
Affordable Care Act (ACA) On-Exchange	Medicare Advantage	- Member must disenroll via the Exchange (either Federal or State). - Enrollment changes are received via file from the Exchanges. - Member must have a valid election to enroll into Medicare Advantage. Application must be received by the plan PRIOR to the effective date.
Affordable Care Act (ACA) Off-Exchange	Medicare Advantage	- Member must have a valid election to enroll into Medicare Advantage and application must be received by the plan PRIOR to the effective date. - Member can call Member Service to disenroll from their off-exchange coverage or fill out a change form requesting the cancellation. - Members will be disenrolled on the first of the following month after it is received OR the paid-to date.
Affordable Care Act (ACA) On-Exchange	Medicare Supplement	- Member must disenroll via the Exchange (either Federal or State)/ Enrollment changes are received via file from the Exchanges. - Member can then be enrolled in Medigap once Proof of Prior Creditable Coverage documentation received from the applicant. - If their ACA Coverage was also with Highmark and they now want to enroll in a Highmark Medigap Plan, a letter is not required to show proof of prior coverage, but we cannot move forward with a Medigap enrollment without an end date to their group coverage appearing in Highmark’s system.
Affordable Care Act (ACA) Off-Exchange	Medicare Supplement	- Member can call Member Service to disenroll from their off-exchange coverage or fill out a change form requesting the cancellation. - Members will be disenrolled on the first of the following month after it is received OR the paid-to date. - Member can then be enrolled in Medigap once Proof of Prior Creditable Coverage documentation received from the applicant. - If their ACA Coverage was also with Highmark and they now want to enroll in a Highmark Medigap Plan, a letter is not required to show proof of prior coverage, but we cannot move forward with a Medigap enrollment without an end date to their group coverage appearing in Highmark’s system.

Enrollment/Disenrollment Member Responsibilities Quick Reference, cont.

Disenroll FROM	Enroll INTO	Member Responsibility
Group Health Care	ACA On-Exchange	- Member must notify their employer as to when their group coverage should end, and the new coverage will begin. - Member has to enroll VIA the Exchanges (either Federal or State).
Group Health Care	ACA Off-Exchange	- Member must notify their employer as to when their group coverage should end, and the new coverage will begin. - Member can enroll directly with Highmark. - Outside of Open Enrollment Period, a valid SEP is needed, accompanied by all required documentation; effective date will be the first the following month.
Group Health Care	Medicare Advantage	Member must notify their employer as to when their group coverage should end, and the new coverage will begin.
Group Health Care	Medicare Supplement	Member must notify their employer as to when their group coverage should end, and the new coverage will begin.

On-Exchange vs. Off-Exchange Application Processing Guidelines

The following scenarios outline important guidelines when submitting On-Exchange and Off-Exchange Applications with the same effective dates. Each scenario details the order of application submission and the resulting application outcome. Please familiarize yourself with these outcomes to ensure consistent and accurate enrollment:

Scenario 1

If an On-Exchange Application is submitted prior to an Off-Exchange Application with the same effective date, Highmark would process the application contained within the file from the state.

Scenario 2

If an Off-Exchange Application is submitted prior to an On-Exchange Application with the same effective date, the Off-Exchange Application would be cancelled by the On-Exchange Application.

Notes

This image shows a full page of blank handwriting practice paper. It features approximately 20 evenly spaced, horizontal blue lines across the entire width of the page. The background is a solid off-white color, providing a clear contrast for the blue lines. There are no margins, text, or other markings present.

Legal info

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, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life, Highmark Wholcare or Highmark Senior Health Company.

Central and Southeastern PA: Highmark Inc.
d/b/a Highmark Blue Shield, Highmark Benefits
Group Inc., Highmark Health Insurance Company,
Highmark Wholecare, Highmark Choice Company
or Highmark Senior Health Company.

PA: Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.

Delaware: Highmark BCBSDE 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. **Visit [https://www.
highmarkbcbswv.com/content/dam/highmark/
en/highmarkbcbswv/member/redesign/pdfs/
mhs/NetworkAccessPlan.pdf](https://www.highmarkbcbswv.com/content/dam/highmark/en/highmarkbcbswv/member/redesign/pdfs/mhs/NetworkAccessPlan.pdf) to view the
Access Plan required by the Health Benefit
Plan Network Access and Adequacy Act. You
may also request a copy by contacting us at the
number on the back of your ID card.**

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

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.

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