Over 80 years of security and stability.

Highmark Blue Shield is part of a network that's been providing peace of mind for the better part of a century.
And with 1 in 3* Americans covered by that same network today, when you're with Highmark, you're in good company.

Questions about how your Freedom Blue PPO Medicare Advantage plan works?

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

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

Three easy steps to get you enrolled.

step 1

Fill out everything in your Group Enrollment Application.

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

step 2

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

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

step 3

Return your completed application in the envelope provided.

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

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

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

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

Grab a pen and turn the page to start your application.

ENROLLMENT APPLICATIONS

Let’s get you signed up.

ENROLLMENT APPLICATION

INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

Read all of the information carefully and answer the questions to the best of your knowledge.

Print neatly and legibly. If you have questions or need assistance filling out this enrollment application, call us at the toll free number listed below and a knowledgeable representative will assist you. Be sure to sign and date the application and return the top copy. The bottom copy should be retained for your own records.

STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

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

I understand that Freedom Blue PPO, will notify me in writing of my confirmed effective date of enrollment in Freedom Blue PPO. I understand that, typically, my effective date will be the first of the month following the month in which Freedom Blue PPO receives my completed enrollment application. I understand that I may want to consider not cancelling any Medicare supplement plan or Medigap/Medicare Select plan until I am notified in writing of my confirmed effective date in Freedom Blue PPO.

Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal.

Freedom Blue PPO is a Medicare Advantage Plan and has a contact with the Federal government. I will need to keep my Medicare Parts A and Part B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

You can also apply for extra help on-line at www.socialsecurity.gov/prescriptionhelp. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this Plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under special circumstances.

Once I am a member of Freedom Blue PPO, I have the right to appeal Plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Freedom Blue PPO when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I understand that the Freedom Blue PPO marketing materials, such as the Summary of Benefits, present only highlights of plans and options, not details.

STATEMENTS OF UNDERSTANDING AND AUTHORIZATION (CONTINUED)

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

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Freedom Blue PPO, he/she may be paid based on my enrollment in Freedom Blue PPO.

RELEASE OF INFORMATION:

By joining this Medicare health plan, I acknowledge that Freedom Blue PPO will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Freedom Blue PPO will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

PERSONAL HEALTH INFORMATION

I acknowledge and agree that any "protected health information" (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Blue Shield may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Blue Shield's Notice of Privacy Practices is available on Highmark Blue Shield's Web site, or from the Highmark Blue Shield Privacy Department.

PART-D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. DO NOT pay Freedom Blue PPO the Part D-IRMAA.

Please return the top copy of both pages of the application and keep the bottom copies for your records.

HIGHMARK

Former Employer Complete This Section	
Employer's Signature and Date:	Effective Date:

TO ENROLL IN FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

First Name	Middle Initial (if applicable)	Last Name	Suffix	Sex ❑ Male ❑ Female

Home Address (No P.O. Boxes)	Apt#	City	State	Zip	County
Mailing Address (P.O. Boxes allowed)	Apt#	City	State	Zip	Date of Birth / /

Home Phone (with area code) ( )	Email Address (if applicable)

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

–OR–

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

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

IS ENTITLED TO _____
EFFECTIVE DATE

HOSPITAL (Part A): _____

MEDICAL (Part B): _____

You must have Medicare Part A and Part B (or both) to join a Medicare Advantage plan.

YOU WANT TO ENROLL IN:

☒ 0178322

Lafayette College

OTHER INSURANCE

1. Are you currently enrolled in a non-Medicare Highmark Blue Shield health plan? .....Yes ❑ No ❑
   If YES, name of plan: _____
2. Will either you or your spouse be employed once enrolled in Freedom Blue PPO? ..... Self: .....Yes ❑ No ❑ Spouse: ..... Yes ❑ No ❑
   Your Retirement Date (Month/Day/Year): _____ Spouse's Retirement Date (Month/Day/Year): _____
3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Freedom Blue PPO or Medicare that will continue after your enrollment? ..... Yes ❑ No ❑

If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.

READ AND ANSWER THESE IMPORTANT QUESTIONS

Please choose the name of a Primary Care Provider (PCP), clinic or health center.

Name of Provider (recommended)	PCP/NPI # (from Provider Directory)

The Freedom Blue PPO provider directory is available in a CD-ROM format for your computer. Please check here to receive your provider directory in CD-ROM. ❑

Are you currently enrolled in another Medicare Advantage plan? *(Confirmed enrollment in Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.)* .... Yes ❑ No ❑

Are you enrolled in your State Medicaid program? .....Yes ❑ No ❑

If "YES," please provide your Medicaid Number: _____

Are you a resident in a long term care facility such as a nursing home? .....Yes ❑ No ❑

If "YES," please provide the following information:

Name of Institution: _____

Address and Phone Number of Institution (number and street): _____

STOP! If you belong to an employer group or trust fund health plan whose drug coverage is as good as or better than standard Medicare Prescription Drug Coverage (Part D). It is important that you consider your decision to enroll in our plan carefully. In order to finalize your request for enrollment in our plan, we need you to confirm that you want to be enrolled in this group sponsored plan by signing below.

READ AND SIGN BELOW

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Freedom Blue PPO, or by Medicare.

Signature	Today's Date

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

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee: _____

OPTIONAL INFORMATION

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

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

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

What's your race? Select all that apply.

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

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

- ❑ I would like to receive my materials in a language other than English.

- ❑ I would like to receive my materials in an accessible format (Braille, Large Print, Etc.)

Please contact Freedom Blue PPO at **1-800-550-8722** (TTY users should call 711) to inquire about materials in an accessible format, a language other than English, or for telephone translation services. Our office hours are 8 AM - 8 PM, Monday to Sunday.

HIGHMARK

Former Employer Complete This Section	
Employer's Signature and Date:	Effective Date:

TO ENROLL IN FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

First Name | Middle Initial (if applicable) | Last Name | Suffix | Sex ❑ Male ❑ Female

Home Address (No P.O. Boxes) | Apt# | City | State | Zip | County

Mailing Address (P.O. Boxes allowed) | Apt# | City | State | Zip | Date of Birth / /

Home Phone (with area code) ( )

Email Address (if applicable)

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

–OR–

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

Name (as it appears on your Medicare card):

Medicare Number: _____

IS ENTITLED TO _____
EFFECTIVE DATE

HOSPITAL (Part A): _____

MEDICAL (Part B): _____

You must have Medicare Part A and Part B (or both) to join a Medicare Advantage plan.

YOU WANT TO ENROLL IN:

☒ 0178322

Lafayette College

OTHER INSURANCE

1. Are you currently enrolled in a non-Medicare Highmark Blue Shield health plan? .....Yes ❑ No ❑
   If YES, name of plan: _____
2. Will either you or your spouse be employed once enrolled in Freedom Blue PPO? ..... Self: .....Yes ❑ No ❑ Spouse: ..... Yes ❑ No ❑
   Your Retirement Date (Month/Day/Year): _____ Spouse's Retirement Date (Month/Day/Year): _____
3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Freedom Blue PPO or Medicare that will continue after your enrollment? ..... Yes ❑ No ❑

If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.

Keep this copy

READ AND ANSWER THESE IMPORTANT QUESTIONS

Please choose the name of a Primary Care Provider (PCP), clinic or health center.

Name of Provider (recommended)	PCP/NPI # (from Provider Directory)

The Freedom Blue PPO provider directory is available in a CD-ROM format for your computer. Please check here to receive your provider directory in CD-ROM. ❑

Are you currently enrolled in another Medicare Advantage plan? *(Confirmed enrollment in Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.)* .... Yes ❑ No ❑

Are you enrolled in your State Medicaid program? .....Yes ❑ No ❑

If "YES," please provide your Medicaid Number: _____

Are you a resident in a long term care facility such as a nursing home? .....Yes ❑ No ❑

If "YES," please provide the following information:

Name of Institution: _____

Address and Phone Number of Institution (number and street): _____

STOP! If you belong to an employer group or trust fund health plan whose drug coverage is as good as or better than standard Medicare Prescription Drug Coverage (Part D). It is important that you consider your decision to enroll in our plan carefully. In order to finalize your request for enrollment in our plan, we need you to confirm that you want to be enrolled in this group sponsored plan by signing below.

READ AND SIGN BELOW

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Freedom Blue PPO, or by Medicare.

Signature	Today's Date

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

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee: _____

OPTIONAL INFORMATION

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

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

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

What's your race? Select all that apply.

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

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

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

❑ I would like to receive my materials in an accessible format (Braille, Large Print, Etc.)

Please contact Freedom Blue PPO at **1-800-550-8722** (TTY users should call 711) to inquire about materials in an accessible format, a language other than English, or for telephone translation services. Our office hours are 8 AM - 8 PM, Monday to Sunday.

HIGHMARK

Former Employer Complete This Section	
Employer's Signature and Date:	Effective Date:

TO ENROLL IN FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

First Name	Middle Initial (if applicable)	Last Name	Suffix	Sex ❑ Male ❑ Female

Home Address (No P.O. Boxes)	Apt#	City	State	Zip	County
Mailing Address (P.O. Boxes allowed)	Apt#	City	State	Zip	Date of Birth / /

Home Phone (with area code) ( )	Email Address (if applicable)

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

–OR–

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

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

IS ENTITLED TO _____
EFFECTIVE DATE

HOSPITAL (Part A): _____

MEDICAL (Part B): _____

You must have Medicare Part A and Part B (or both) to join a Medicare Advantage plan.

YOU WANT TO ENROLL IN:

☒ 0178322

Lafayette College

OTHER INSURANCE

1. Are you currently enrolled in a non-Medicare Highmark Blue Shield health plan? .....Yes ❑ No ❑
   If YES, name of plan: _____
2. Will either you or your spouse be employed once enrolled in Freedom Blue PPO? ..... Self: .....Yes ❑ No ❑ Spouse: ..... Yes ❑ No ❑
   Your Retirement Date (Month/Day/Year): _____ Spouse's Retirement Date (Month/Day/Year): _____
3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Freedom Blue PPO or Medicare that will continue after your enrollment? ..... Yes ❑ No ❑

If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.

READ AND ANSWER THESE IMPORTANT QUESTIONS

Please choose the name of a Primary Care Provider (PCP), clinic or health center.

Name of Provider (recommended)	PCP/NPI # (from Provider Directory)

The Freedom Blue PPO provider directory is available in a CD-ROM format for your computer. Please check here to receive your provider directory in CD-ROM. ❑

Are you currently enrolled in another Medicare Advantage plan? *(Confirmed enrollment in Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.)* .... Yes ❑ No ❑

Are you enrolled in your State Medicaid program? .....Yes ❑ No ❑

If "YES," please provide your Medicaid Number: _____

Are you a resident in a long term care facility such as a nursing home? .....Yes ❑ No ❑

If "YES," please provide the following information:

Name of Institution: _____

Address and Phone Number of Institution (number and street): _____

STOP! If you belong to an employer group or trust fund health plan whose drug coverage is as good as or better than standard Medicare Prescription Drug Coverage (Part D). It is important that you consider your decision to enroll in our plan carefully. In order to finalize your request for enrollment in our plan, we need you to confirm that you want to be enrolled in this group sponsored plan by signing below.

READ AND SIGN BELOW

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Freedom Blue PPO, or by Medicare.

Signature	Today's Date

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

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee: _____

OPTIONAL INFORMATION

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

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

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

What's your race? Select all that apply.

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

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- ❑ I would like to receive my materials in a language other than English.

- ❑ I would like to receive my materials in an accessible format (Braille, Large Print, Etc.)

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HIGHMARK

Former Employer Complete This Section	
Employer's Signature and Date:	Effective Date:

TO ENROLL IN FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

First Name | Middle Initial (if applicable) | Last Name | Suffix | Sex ❑ Male ❑ Female

Home Address (No P.O. Boxes) | Apt# | City | State | Zip | County

Mailing Address (P.O. Boxes allowed) | Apt# | City | State | Zip | Date of Birth / /

Home Phone (with area code) ( )

Email Address (if applicable)

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

–OR–

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

Name (as it appears on your Medicare card):

Medicare Number: _____

IS ENTITLED TO _____
EFFECTIVE DATE

HOSPITAL (Part A): _____

MEDICAL (Part B): _____

You must have Medicare Part A and Part B (or both) to join a Medicare Advantage plan.

YOU WANT TO ENROLL IN:

☒ 0178322

Lafayette College

OTHER INSURANCE

1. Are you currently enrolled in a non-Medicare Highmark Blue Shield health plan? .....Yes ❑ No ❑
   If YES, name of plan: _____
2. Will either you or your spouse be employed once enrolled in Freedom Blue PPO? ..... Self: .....Yes ❑ No ❑ Spouse: ..... Yes ❑ No ❑
   Your Retirement Date (Month/Day/Year): _____ Spouse's Retirement Date (Month/Day/Year): _____
3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Freedom Blue PPO or Medicare that will continue after your enrollment? ..... Yes ❑ No ❑

If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.

Keep this copy

READ AND ANSWER THESE IMPORTANT QUESTIONS

Please choose the name of a Primary Care Provider (PCP), clinic or health center.

Name of Provider (recommended)	PCP/NPI # (from Provider Directory)

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Are you enrolled in your State Medicaid program? .....Yes ❑ No ❑

If "YES," please provide your Medicaid Number: _____

Are you a resident in a long term care facility such as a nursing home? .....Yes ❑ No ❑

If "YES," please provide the following information:

Name of Institution: _____

Address and Phone Number of Institution (number and street): _____

STOP! If you belong to an employer group or trust fund health plan whose drug coverage is as good as or better than standard Medicare Prescription Drug Coverage (Part D). It is important that you consider your decision to enroll in our plan carefully. In order to finalize your request for enrollment in our plan, we need you to confirm that you want to be enrolled in this group sponsored plan by signing below.

READ AND SIGN BELOW

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Freedom Blue PPO, or by Medicare.

Signature	Today's Date

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

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee: _____

OPTIONAL INFORMATION

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

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

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

What's your race? Select all that apply.

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

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

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

❑ I would like to receive my materials in an accessible format (Braille, Large Print, Etc.)

Please contact Freedom Blue PPO at **1-800-550-8722** (TTY users should call 711) to inquire about materials in an accessible format, a language other than English, or for telephone translation services. Our office hours are 8 AM - 8 PM, Monday to Sunday.

Other Insurance Addendum

If you answered YES to having any other Health Insurance or Prescription Drug coverage, please complete and return this form with your application. If you answered NO, you do not need to complete or return this form.

Name _____ Medicare Number _____

Please specify the type of insurance:

- ❑ Active Employer Group Insurance
- ❑ Retiree Coverage
- ❑ Veteran's Administration Coverage
- ❑ Direct Pay Policy
- ❑ Federal Black Lung Coverage
- ❑ Supplemental Coverage
- ❑ Workman's Compensation Coverage

Please specify type of coverage:

- ❑ Medical Only
- ❑ Medical with Prescription Drugs
- ❑ Dental or Vision Only
- ❑ Prescription Drug Only

Is this insurance provided by: ❑ Your Employer ❑ Your Spouse's Employer ❑ Individual Plan

Does your employer have: ❑ 1-19 employees ❑ 20-99 employees ❑ more than 100 employees

Does your spouse's employer have: ❑ 1-19 employees ❑ 20-99 employees ❑ more than 100 employees

Your employer's name: _____ **Your insurance name:** _____

Your insurance policy #: _____ **Your insurance group #:** _____

Spouse's employer's name: _____ **Spouse's insurance name:** _____

Spouse's insurance policy #: _____ **Spouse's insurance group #:** _____

Member's Signature* _____ Date _____

* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized to under State law to complete this form and 2) documentation of this authority is available upon request by the plan or Medicare.

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

Name: _____ Phone: _____

Address: _____ Relationship to Enrollee: _____

Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark's Senior Health Company depends on contract renewal.

SUMMARY OF BENEFITS

Here's your Medicare Advantage plan in a nutshell.

HIGHMARK.

Because Life.™

Freedom Blue PPO

Summary of Benefits

January 1, 2024, to December 31, 2024

Thank you for your interest in Freedom Blue PPO. Our plan is offered by Highmark Senior Health Company, a Medicare Advantage Preferred-Provider Organization (PPO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or every limitation or every exclusion. You will receive a full list of benefits with your Welcome Kit once you are enrolled. You can request an Evidence of Coverage by calling Member Service at 1-866-456-7739 (TTY users may call 711), Monday – Friday, 8 a.m. – 4:30 p.m. ET.

You have choices in your health care.

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare plan. Another option is a Medicare Advantage health plan, like Freedom Blue PPO. You may have other options, too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may join or leave a plan only at certain times. Please call Freedom Blue PPO at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, seven days a week.

How can I compare my options?

You can compare Freedom Blue PPO and the Original Medicare plan using this Summary of Benefits and visiting **medicare.gov**. For each benefit, you can compare what our plan covers and what the Original Medicare plan covers.

Our members receive all of the benefits that the Original Medicare plan offers. We also offer more benefits, which may change from year to year.

Where is Freedom Blue PPO available?

The service area for this plan varies. Please contact Freedom Blue PPO for more information.

Who is eligible to join Freedom Blue PPO?

You can join Freedom Blue PPO if you are entitled to Medicare Part A and enrolled in Medicare Part B.

More about Original Medicare:

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

Can I choose my doctors?

Freedom Blue PPO has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers within our network can change at any time. Also, the doctors and hospitals available to you may vary, depending on where you reside. You can ask for a current Provider Directory or, for an up-to-date list, visit us at **highmarkblueshield.com/find-a-doctor**. Our Customer Service number is listed at the end of this introduction.

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

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. For a full list of cost sharing that applies to out-of-network services, please see the Summary of Benefits included in this document. For more information, please call the Customer Service number at the end of this introduction.

What should I do if I have other insurance in addition to Medicare?

If you have a Medigap (Medicare Supplement) policy, you must contact your Medigap issuer to let them know that you have joined a Medicare plan. Call your Medigap issuer for details.

Does my plan cover Medicare Part B or Part D drugs?

Freedom Blue PPO does cover Medicare Part B Prescription Drugs. Freedom Blue PPO also covers Medicare Part D Prescription Drugs.

Where can I get my prescriptions if I join this plan?

Freedom Blue PPO has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy except in certain cases. The pharmacies in our network can change at any time. You can ask for a current pharmacy directory, or visit us at **highmarkblueshield.com/find-a-doctor**. Our Customer Service number is listed at the end of this introduction.

What is a prescription drug formulary?

Freedom Blue PPO uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug.

If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at **medicare.highmark.com/resources/aep-formularies**. If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

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

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

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

What are prescription drug care management programs?

With your plan, certain clinical programs help ensure that your medications are prescribed and dispensed the right way. They balance positive benefits to you and monitor certain prescription drugs that could need special permissions or have quantity level limits. Overall, these programs are designed to help keep you safe.

What are my protections in the plan?

All Medicare Advantage plans agree to stay in the Medicare program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Freedom Blue PPO, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision.

Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state.

As a member of Freedom Blue PPO, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug.

If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision.

Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state.

What is a medication therapy management (MTM) program?

A medication therapy management (MTM) program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact Freedom Blue PPO for more details.

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

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Freedom Blue PPO for more details.

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

Questions about drug coverage?

Call **1-866-456-7739** Monday thru Friday, 8:00am - 4:30pm EST
(TTY call 711).

Where can I find information on plan ratings?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients, and customer service). If you have access to the web, you may use the web tools on **medicare.gov** and select **Health and Drug Plans** or **Compare Drug and Health Plans** to compare the plan ratings of Medicare plans in your area. You can also call us directly at **1-800-550-8722** to obtain a copy of the plan ratings for this plan. TTY users call 711.

Please call Highmark Senior Health Company for more information about this plan.

Current members

Call **1-800-550-8722** for questions related to the Medicare Advantage program or Medicare Part D Prescription Drug program (TTY/TDD 711), seven days a week, 8 a.m. – 8 p.m. ET

Prospective members

Call **1-866-456-7739** for questions related to the Medicare Advantage or Medicare Part D Prescription Drug program (TTY/TDD 711), Monday – Friday, 8 a.m. – 4:30 p.m. ET.

For more information about Medicare, call **1-800-MEDICARE** (1-800-633-4227). TTY users should call **1-877-486-2048**. You can call 24 hours a day, seven days a week. Or, visit **medicare.gov**.

This document may be available in other formats such as Braille, large print, or other alternate formats. This document may be available in a non-English language. For additional information, call Customer Service at the phone number listed above.

	2024 Freedom Blue PPO Summary of Benefits	
	Freedom Blue PPO (PA) In-Network	**Freedom Blue PPO (PA) Out-of-Network**
Important Information		
Premium and Other Important Information	You may pay a premium each month to your retiree/employer group/trust fund. In addition, you keep paying your Medicare Part B premium. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income, visit www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	
Plan Deductible	$800	
In Network Out-of-Pocket Maximum (does not include Part D Drugs)	$1,600	
Combined In and Out-of-Network Out-of-Pocket Maximum (does not include Part D Drugs)	$3,400	
Covered Medical and Hospital Benefits		
Note:	Services with a 1 may require prior authorization.	
Inpatient Hospital Care[1] (includes Substance Abuse and Rehabilitation Services) Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	You pay: 15% Coinsurance for each stay.	You pay: 30% Coinsurance for each stay.
Outpatient Hospital/Ambulatory Surgery Center[1]	You pay: 15% Coinsurance	You pay: 30% Coinsurance

Doctor Office Visits Office visit copays do not apply to the annual deductible if applicable	You pay: $15 Copay Primary Care Physician visit You pay: $25 Copay Specialist visit	You pay: 30% Coinsurance Primary Care Physician visit You pay: 30% Coinsurance Specialist visit
Preventive Services	You pay: $0 copay Our plan covers many preventive services, including: Abdominal Aortic Aneurysm Screening, Alcohol misuse counseling, Bone Mass Measurement, Breast cancer screening (mammogram), Cardiovascular disease (behavioral therapy), Cardiovascular screenings, Cervical and Vaginal Cancer Screening, Colorectal Cancer Screening (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy), Depression screening, Diabetes Screening, HIV screening, Medical nutrition therapy services, Obesity screening and counseling, Prostate cancer screenings (PSA), Sexually transmitted infections screening and counseling, Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease), Vaccine, including Flu shots,Hepatitis B shots, Pneumococcal shots, "Welcome to Medicare" preventive visit (one-time), Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. If the doctor provides you additional services, separate doctor office visit cost sharing may apply.	
Emergency Care You may go to any emergency room if you reasonably believe you need emergency care.	You pay $75 Copay for each emergency room visit. Worldwide coverage for emergency and urgently needed care. If you are admitted to the hospital within 3-day(s) for the same condition, your copay is waived for the emergency room visit.	
Urgent Care This is **not** emergency care	You pay: $40 Copay	

Services with a 1 may require prior authorization

Diagnostic Tests, Lab, Radiology Services[1] Such as MRIs and CT Scans and X-rays	You pay: 15% Coinsurance for lab/diagnostic services in a physicians office or independent lab. You pay: 15% Coinsurance for lab/diagnostic services in an outpatient facility. You pay: 15% Coinsurance for standard imaging services. You pay: 15% Coinsurance for advanced imaging services. You pay: $0 Copay for therapeutic radiology services.	You pay: 30% Coinsurance for lab/diagnostic services in a physicians office or independent lab. You pay: 30% Coinsurance for lab/diagnostic services in an outpatient facility. You pay: 30% Coinsurance for standard imaging services You pay: 30% Coinsurance for advanced imaging services. You pay: 30% Coinsurance for therapeutic radiology services.
Hearing Services Medicare covered Exam to diagnose and treat hearing and balance issues	You pay: $25 Copay	You pay: 30% Coinsurance
Hearing Services Routine Exam up to 1 every year. Cost sharing is not applied to the Combined In and Out-of-Network Out-of-Pocket Maximum.	You pay: $25 Copay	You pay: 30% Coinsurance
	$499 copay per aid per year for TruHearing Advanced. $799 copay per aid per year for TruHearing Premium.	$500 allowance for hearing aids every 3 years from any other provider.
Dental Services[1] Preventive dental services (such as cleaning) not covered Authorization rules may apply for Medicare-covered accidental dental services.	Medicare covered dental benefits you pay: $25 Copay.	Medicare covered dental benefits you pay: 30% Coinsurance.
Vision Medicare covered Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	You pay: $25 Copay $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.	You pay: 30% Coinsurance $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.

Services with a 1 may require prior authorization

Routine Vision	Routine eye exam (for up to 1 every year) you pay: $0 Copay Eye Wear Limited to one pair of eyeglass frames with eyeglass lenses or contact lenses every calendar year. Davis Vision Fashion Collection eyeglass frames, standard eyeglass lenses and standard contact lenses are covered in full. A $150 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses.	You pay: $50 Copay for routine eye exams. A $150 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses.
Mental Health Care[1] Office visit copays do not apply to the annual deductible.	Inpatient visit: Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital . Inpatient stay you pay: 15% Coinsurance Outpatient group therapy visit you pay: $25 Copay Outpatient individual therapy visit you pay: $25 Copay	Inpatient stay you pay: 30% Coinsurance Outpatient group therapy visit you pay: 30% Coinsurance Outpatient individual therapy visit you pay: 30% Coinsurance
Skilled Nursing Facility (SNF)[1] Medicare-certified skilled nursing facility	You pay: $20 Copay per admission for days 1-20. Then 15% Coinsurance per admission for days 21-100. No prior hospital stay is required.	You pay: 30% Coinsurance per admission for days 1-100. No prior hospital stay is required.

Services with a 1 may require prior authorization

Physical Therapy[1]	You pay: $25 Copay for Medicare-covered Physical Therapy visits.	You pay: 30% Coinsurance for Medicare-covered Physical Therapy visits.
Ambulance Services[1] Medically necessary ambulance services	You pay: 15% Coinsurance	Emergency - You pay: 15% Coinsurance Non-Emergency - You pay: 30% Coinsurance
Transportation (Routine)[1] Combined 24 one way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.	You pay: $10 Copay per trip.	You pay: 50% Coinsurance for out-of-network transportation services.
Part B Drugs[1] Drugs covered under Medicare Part B. See Section 1 for more Information on Medicare Part B Drugs. In-network Part B covered chemotherapy drugs and other in-network Part B covered Drugs	You pay: 15% Coinsurance	You pay: 30% Coinsurance
Acupuncture Medicare-covered Acupuncture visits up to 12 visits in 90 days for chronic low back pain	You pay: $25 Copay for Medicare-covered Acupuncture visits.	You pay: 30% Coinsurance for Medicare-covered Acupuncture visits.
Chiropractic Care[1] Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part)	You pay: $20 Copay	You pay: 30% Coinsurance

Services with a 1 may require prior authorization

Diabetes Supplies and Services[1] includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes	You pay: 15% Coinsurance Diabetes self-management training you pay: $0 Copay. If the doctor provides you additional services, separate doctor office visit cost sharing may apply.	You pay: 30% Coinsurance
Durable Medical Equipment[1] Includes wheelchairs, prosthetics, oxygen, etc.	You pay: 15% Coinsurance for durable medical equipment. You pay: 15% Coinsurance for oxygen and oxygen supplies.	You pay: 30% Coinsurance for durable medical equipment. You pay: 30% Coinsurance for oxygen and oxygen supplies.
Foot Care *(podiatry services)* Medicare covered exam -Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	You pay: $25 Copay	You pay: 30% Coinsurance
Home Health Care[1]	You pay: 15% Coinsurance	You pay: 30% Coinsurance
Outpatient Rehabilitation[1] Cardiac Rehabilitation (maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks), **Occupational Therapy, Physical Therapy, Speech and Language Therapy**	You pay: $0 Copay for Cardiac (heart) Rehabilitation services. You pay: $25 Copay for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.	You pay: 30% Coinsurance for Cardiac (heart) Rehabilitation services. You pay: 30% Coinsurance for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.
Over the Counter Drug Allowance	Not Covered	
Renal Dialysis Services to Treat Kidney Disease	You pay: $0 Copay	You pay: 30% Coinsurance

Services with a 1 may require prior authorization

Wellness/Education and Other Supplemental Benefits & Services	The plan covers the following supplemental education/wellness programs: SilverSneakers Membership/Fitness Classes	You pay: 50% of the cost for out-of-network health/wellness services after a $500 deductible.
Hospice	You pay: $0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	
OnDuo (Diabetic)	Covered	

Services with a 1 may require prior authorization

Part D Prescription Drug Benefits

DRUG

After you pay your yearly deductible of $250, you pay the following until total yearly drug costs reach $5,030. Total yearly drug costs are the total drug cost paid by both you and a part D plan.

Initial Coverage

Preferred Retail Pharmacy

Tier	31 Day Supply	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
Tier 1 (Preferred Generic Drugs)	$10 Copay	$30 Copay
Tier 2 (Generic Drugs)	$10 Copay	$30 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$25 Copay	$75 Copay
Tier 4 (Non-Preferred Drugs)	$55 Copay	$165 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	$60 Copay	Not Available

Network Retail Pharmacy

Tier	31 Day Supply	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
Tier 1 (Preferred Generic Drugs)	$15 Copay	$45 Copay
Tier 2 (Generic Drugs)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$30 Copay	$90 Copay
Tier 4 (Non-Preferred Drugs)	$60 Copay	$180 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	$60 Copay	Not Available

Mail Order (Express Scripts)

Tier	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
Tier 1 (Preferred Generic Drugs)	$25 Copay
Tier 2 (Generic Drugs)	$25 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$62.50 Copay
Tier 4 (Non-Preferred Drugs)	$137.50 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	$60 Copay for a 31 day limit supply

Mail Order (All other Mail Order Pharmacies)

Tier	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
Tier 1 (Preferred Generic Drugs)	$37.50 Copay
Tier 2 (Generic Drugs)	$37.50 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$75 Copay
Tier 4 (Non-Preferred Drugs)	$150 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	$60 Copay for a 31 day limit supply

Coverage Gap

Preferred Retail Pharmacy

Tier	31 Day Supply	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
Tier 1 (Preferred Generic Drugs)	$10 Copay	$30 Copay
Tier 2 (Generic Drugs)	$10 Copay	$30 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$25 Copay	$75 Copay
Tier 4 (Non-Preferred Drugs)	$55 Copay	$165 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	$60 Copay	Not Available

Network Retail Pharmacy

Tier	31 Day Supply	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
Tier 1 (Preferred Generic Drugs)	$15 Copay	$45 Copay
Tier 2 (Generic Drugs)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$30 Copay	$90 Copay
Tier 4 (Non-Preferred Drugs)	$60 Copay	$180 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	$60 Copay	Not Available

Mail Order (Express Scripts)

Tier	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
Tier 1 (Preferred Generic Drugs)	$25 Copay
Tier 2 (Generic Drugs)	$25 Copay
Tier 3 (Preferred Brand Drugs and Generics)	$62.50 Copay
Tier 4 (Non-Preferred Drugs)	$137.50 Copay
Tier 5 (Specialty drugs consist of both Generic and Brand)	$60 Copay for a 31 day limit supply

DRUG	Coverage Gap	Mail Order (All other Mail Order Pharmacies)	Tier	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
			Tier 1 (Preferred Generic Drugs))	$37.50 Copay
			Tier 2 (Generic Drugs)	$37.50 Copay
			Tier 3 (Preferred Brand Drugs and Generics)	$75 Copay
			Tier 4 (Non-Preferred Drugs)	$150 Copay
			Tier 5 (Specialty drugs consist of both Generic and Brand)	$60 Copay for a 31 day limit supply
		The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. You will remain in the coverage gap until your costs (includes the 70% manufacturer discount) total $8,000. Not everyone will enter the coverage gap.		
	Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.		
	Formulary	Incentive		
	Important Message If you have prescription cost sharing more than $35/month - What You Pay for Insulin – The maximum copayment for a one-month supply of covered insulin products is $35, no matter what cost-sharing tier it is on or if you have not met your Rx deductible (if applicable).			

For questions about this plan's benefits or costs, please contact Freedom Blue PPO (PA). Call 1-866-456-7739, (TTY users call 711), Monday thru Friday, 8:00am - 4:30pm EST. Please have Reference Code 24FB0178322 ready when you call.

This information is not a complete description of benefits. Call **1-866-456-7739** (TTY users may call 711) for more information.

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

Benefits and/or benefit administration may be provided by or through the following entities which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company.

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.

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

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

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-844-679-6930. (TTY:711)

请注意：如果您说中文，可向您提供免费语言协助服务。請致電 1-844-679-6930。(TTY:711)

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HIGHMARK.

Because Life.™

Understanding your drug formulary

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

What is a formulary?

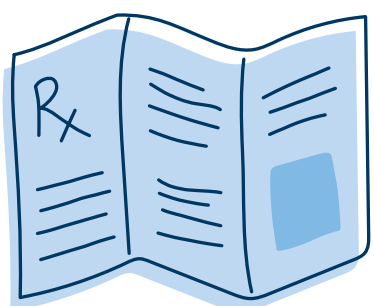
The formulary is a list of FDA-approved prescription drugs and selected over-the-counter medications. The drugs on the formulary are divided into major categories, depending on the medical condition they are used to treat.

Got it. So what are the categories?

Highmark's drug formulary is divided into three categories:

1. Performance
2. Venture
3. Incentive

All of our 2024 plans use the Performance Formulary, Venture Formulary, or Incentive Formulary. For a complete list of every drug that's covered, you should refer to your plan's specific formulary.



How do I find my plan's specific formulary?

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

Option 1:

Search for a drug at medicare.highmark.com.

You can use our search tool to find a specific drug. All you need to do is complete four simple steps:

1. Visit **medicare.highmark.com**.
2. Scroll to the bottom of the page and click the **Find a Prescription Drug** option.
3. Enter your ZIP code.
4. Search for your plan under the listed formularies. Your formulary type can be found in the Summary of Benefits on the Part D Prescription Drug Benefits page.
5. Select the link to view the formulary.

Option 2:

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

To request a printed copy of your plan's formulary, call the Highmark Customer Service number below.

And remember, if you have questions, you can always call Highmark Customer Service at 1-866-456-7739 (TTY users call 711), Monday – Friday, 8 a.m. – 4:30 p.m.

Highmark is part of a network that's been providing secure and stable health care coverage for over 80 years. And with 1 in 3 Americans* covered by that same network today, when you're with Highmark, you're in good company.

HIGHMARK.

Because Life.™

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

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

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company.

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.

The pharmacy network may change at any time. You will receive notice when necessary. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

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Save money by using preferred pharmacies.

Highmark Blue Shield has relationships with many major pharmacies to help lower your drug costs. If you get your medications at one of the pharmacies listed here, you'll save money. Please view the pharmacy section of your provider and/or pharmacy directory for a complete listing in your area. Make sure your plan qualifies for preferred cost sharing.

CVS, Costco, Giant Eagle, Giant Foods, Kmart, Rite Aid, Sam's Club, Tops Pharmacy, Walmart, Weis, Express Scripts Mail Order, and many independent pharmacies.

Pharmacy network is subject to change.

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

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NETWORK PROVIDER INFO

Where you can go for quality in-network care.

Network provider information

Here's how choosing an out-of-network doctor or hospital could mean you pay more.

While you're close to home, you have access to care through your local network. Use in-network Medicare providers to get care or you could pay extra. Please refer to the Summary of Benefits included in this document for benefits and cost sharing.

If you're traveling outside of your county or across the country, you also have access to care from thousands of other participating Blue Shield Medicare Advantage PPO doctors, hospitals, and other professional providers. If you get care from them, you're covered at the same in-network rates too.

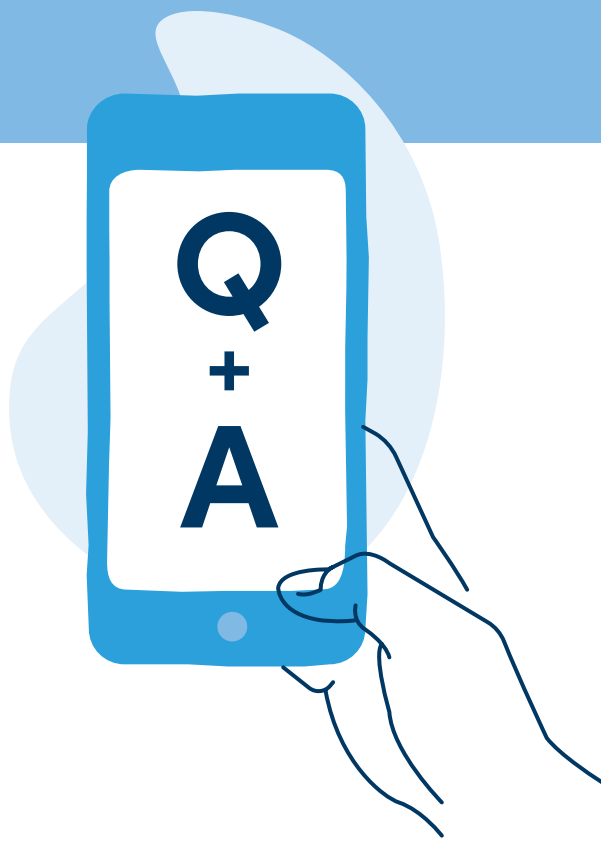
And if you happen to be in a county without a participating MA PPO plan, not to worry. You'll pay those same in-network rates. Just remember, that provider has to accept Medicare. If not, the cost of care won't be covered

So, you're covered at home, and away — at lots of high-quality providers.

If you need help finding an in-network provider, reach out and we'll help.

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

Get help with the ins and outs of your Freedom Blue PPO.



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

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

If you need to find an in-network provider or facility, you can always use our searchable online directory:

1. Visit **highmarkblueshield.com** and click **Find a Doctor** or **Pharmacy**.
2. To find Medicare Advantage providers or facilities, click **Yes**.
3. Click the type of provider you're looking for (Medical, Vision, Dental, or Pharmacy).
4. Select **Network - Freedom Blue PPO** and enter your city and state or your ZIP code.
5. Type the provider or facility you're looking for and hit **Enter**.

As a Freedom Blue PPO member, you're covered for urgent and emergency care worldwide.

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

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

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

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.

Because Life.™

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HEALTH AND WELLNESS

How to find care, get care, and stay healthier.

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

BLUES ON CALL℠

Answers from a health pro, 24/7.

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

TRAVEL BENEFITS (PPO)

Coverage that travels with you.

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

FITNESS

Free exercise and wellness membership through SilverSneakers®.

Stay active with access to over 15,000 nationwide locations. If you can't get to a gym, at-home kits bring the fitness to you. Visit **medicare.highmark.com**. Click **Learn**, enter your ZIP code, then click **Plan Perks and Services** and then **Highmark Fitness**. Or, call us at **1-866-456-7739** (TTY users call 711).

NO REFERRALS

No referrals, no red tape.

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

REWARDS

Get rewarded for taking care of yourself.

To learn about preventive-care-based reward and wellness card programs available to all Highmark Medicare Advantage members, visit **medicare.highmark.com**. Click **Learn**, enter your ZIP code, then click **Plan Perks and Services** and then **Wellness Plans and Rewards**.

VIRTUAL VISITS

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

Need to see a doctor but can't leave home? Get a diagnosis, treatment plan, or prescription any time, right from your phone or computer. Just call **1-844-459-6452** (TTY users call 711).

HIGHMARK HOUSE CALL

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

Get a general wellness exam, suggestions for screenings or other tests, and a medicine review. Call us at **1-866-456-7739** (TTY users call 711) to schedule a house call or visit **medicare.highmark.com**. Click **Learn**, enter your ZIP code, then click **Plan Perks and Services** and then **Highmark House Call**.

REFERENCE

FAQs, helpful definitions, and all the fine print.

Questions about your plan? We have answers.

Is my plan a Medicare Supplement?

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

What's included in my plan?

All Medicare benefits are covered, such as annual checkups, immunizations, and screenings. You may also have extra perks, like routine hearing and eye exams, hearing aids, eyeglasses or contact lenses, and prescription drug coverage. Please refer to the Summary of Benefits included in this kit for benefits and cost sharing. With your PPO plan, you can choose your doctors and hospitals, either in or out of network. And, you don't need referrals.

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

Will I receive high-quality care?

Absolutely. We carefully screen our health care providers before they join our network.

Each provider is evaluated by our medical review committee and must meet strict criteria. We take these steps regularly to ensure we continue offering high-quality care.

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

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

Am I affected by IRMAA?

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

What if I decide to drop my coverage later?

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

Health care lingo, translated.

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

PREMIUM

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

COINSURANCE

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

IN-NETWORK PROVIDER

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

OUT-OF-NETWORK PROVIDER

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

PLAN ALLOWANCE

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

MAXIMUM OUT-OF-POCKET

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

COPAY

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

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

For more complete information about what is and is not covered by Freedom Blue PPO, please refer to the enclosed benefits chart or the Evidence of Coverage that will be available once you are a member of the plan. The benefits described in this brochure are in effect for this calendar year only. Freedom Blue PPO may change benefits with the approval of the Centers for Medicare and Medicaid Services (CMS) at the beginning of each calendar year. Members are mailed written notice in advance of such changes. Highmark Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal. Benefits and/or benefit administration may be provided by or through the following entities which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. 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. SilverSneakers is a registered mark of Tivity Health Inc. Tivity Health Inc., is a separate company that administers the SilverSneakers program. Deductibles, coinsurance and limitations apply to out of-network services except for urgent and emergency care. Contact Freedom Blue PPO representatives for details. With the exception of emergency or urgent care, it may cost more to get care from non-plan or nonpreferred providers. Eligible Medicare beneficiaries may enroll in Medicare-approved plans only during specific times of the year known as enrollment periods. For more information, please contact Highmark Blue Shield Customer Service at 1-866-456-7739 (TTY/TDD users may call 711), Monday – Friday, 8 a.m. – 4:30 p.m. This document may be available in alternate formats or languages. To receive assistance in other languages or formats, please contact 1-866-456-7739 (TTY/TDD users may call 711), Monday – Friday, 8 a.m. – 4:30 p.m. Freedom Blue PPO members may visit any participating Blue Cross and/or Blue Shield Medicare Advantage PPO provider in the United States and pay network cost sharing. Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, except in emergency situations. Please call our customer service number for questions regarding your benefits and cost sharing that applies to out-of-network services, or refer to the summary of benefits section of this document. You will receive a full list of benefits with your Welcome Kit once you are enrolled. You can request an Evidence of Coverage by calling Member Service at 1-866-456-7739 (TTY users may call 711).

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

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

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

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

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

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY:711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты
(номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATANSYON: Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្ម ជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូម ទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់របស់លោកអ្នក (TTY: 711) ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY：711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود تماس بگیرید. (TTY: 711)

DÍÍ BAA'ÁKONÍNÍZIN: Diné bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih. (TTY: 711)