



Medicare Advantage Renewal  
2027 Renewal

Client Name: CASHIC-Schalmont CSD  
Client Number: 296678  
Group Number: 10728345  
Effective Date: 1/1/2027

| Medical Benefits                                                                                                                                                                        | 2026 Benefits                                                                                                                   |                                                                                                                      | 2027 Benefits                                                                                                                   |                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                         | Forever Blue 799 (PPO) Plan CF12 TRx                                                                                            | Forever Blue 799 (PPO) Plan CF12 TRx                                                                                 | Forever Blue 799 (PPO) Plan CF12 TRx                                                                                            | Forever Blue 799 (PPO) Plan CF12 TRx                                                                                     |
| Deductible                                                                                                                                                                              | In-Network                                                                                                                      | Out-of-Network                                                                                                       | In-Network                                                                                                                      | Out-of-Network                                                                                                           |
|                                                                                                                                                                                         | \$0                                                                                                                             | \$0                                                                                                                  | \$0                                                                                                                             | \$0                                                                                                                      |
| Coinurance (see specific benefits for cost sharing)                                                                                                                                     | 0%                                                                                                                              | 20%                                                                                                                  | 0%                                                                                                                              | 20%                                                                                                                      |
| In-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)                     | \$1,250                                                                                                                         | Not Applicable                                                                                                       | \$1,250                                                                                                                         | Not Applicable                                                                                                           |
| Combined In and Out-of-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs) | \$1,250                                                                                                                         |                                                                                                                      | \$1,250                                                                                                                         |                                                                                                                          |
| Physician and other Health Professional Services                                                                                                                                        | In-Network                                                                                                                      | Out-of-Network                                                                                                       | In-Network                                                                                                                      | Out-of-Network                                                                                                           |
| Office Visits - Primary Doctor                                                                                                                                                          | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Office Visits - Specialist                                                                                                                                                              | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Radiation Therapy                                                                                                                                                                       | \$20                                                                                                                            | \$20                                                                                                                 | \$20                                                                                                                            | \$20                                                                                                                     |
| Emergency Room (waived if admitted within 1 day)                                                                                                                                        | \$50                                                                                                                            |                                                                                                                      | \$50                                                                                                                            |                                                                                                                          |
| Urgent Care                                                                                                                                                                             | \$25                                                                                                                            |                                                                                                                      | \$25                                                                                                                            |                                                                                                                          |
| Ambulance (Emergency)                                                                                                                                                                   | \$50                                                                                                                            |                                                                                                                      | \$50                                                                                                                            |                                                                                                                          |
| Ambulance (Non-Emergent)                                                                                                                                                                | \$50                                                                                                                            | \$50                                                                                                                 | \$50                                                                                                                            | \$50                                                                                                                     |
| More than 20 Preventive Services                                                                                                                                                        | In-Network                                                                                                                      | Out-of-Network                                                                                                       | In-Network                                                                                                                      | Out-of-Network                                                                                                           |
| Includes screenings and vaccines such as Flu, Pneumonia, Covid 19, Hepatitis, etc                                                                                                       | Covered in Full                                                                                                                 | Covered in Full                                                                                                      | Covered in Full                                                                                                                 | Covered in Full                                                                                                          |
| Hospital, Home Health Care, and Skilled Services                                                                                                                                        | In-Network                                                                                                                      | Out-of-Network                                                                                                       | In-Network                                                                                                                      | Out-of-Network                                                                                                           |
| Hospital (Inpatient)                                                                                                                                                                    | \$0 per stay                                                                                                                    | 20%                                                                                                                  | \$0 per stay                                                                                                                    | 20%                                                                                                                      |
| Observation Room/Outpatient Surgery (Hospital)                                                                                                                                          | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Outpatient Surgery (Ambulatory Center)                                                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Home Health Care                                                                                                                                                                        | 0%                                                                                                                              | 10%                                                                                                                  | 0%                                                                                                                              | 10%                                                                                                                      |
| Skilled Nursing Facility (100 days per benefit period)                                                                                                                                  | 0% days 1-100                                                                                                                   | 20% days 1-100                                                                                                       | 0% days 1-100                                                                                                                   | 20% days 1-100                                                                                                           |
| Dialysis                                                                                                                                                                                | \$0                                                                                                                             | Inside service area: 20% for non-participating providers. Outside service area: \$0 for non-participating providers. | \$0                                                                                                                             | Inside service area: 20% for non-participating providers. Outside service area: \$0 for non-participating providers.     |
| Mental Health/Chemical Dependence Services                                                                                                                                              | In-Network                                                                                                                      | Out-of-Network                                                                                                       | In-Network                                                                                                                      | Out-of-Network                                                                                                           |
| Mental Health (Inpatient, 180-day lifetime limit)                                                                                                                                       | \$0 per stay                                                                                                                    | 20%                                                                                                                  | \$0 per stay                                                                                                                    | 20%                                                                                                                      |
| Mental Health (Outpatient)                                                                                                                                                              | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Mental Health (Outpatient with Psychiatrist)                                                                                                                                            | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Alcohol Substance Abuse (Inpatient)                                                                                                                                                     | \$0 per stay                                                                                                                    | 20%                                                                                                                  | \$0 per stay                                                                                                                    | 20%                                                                                                                      |
| Alcohol Substance Abuse (Outpatient)                                                                                                                                                    | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Laboratory and X-ray Services                                                                                                                                                           | In-Network                                                                                                                      | Out-of-Network                                                                                                       | In-Network                                                                                                                      | Out-of-Network                                                                                                           |
| Laboratory Testing (Physician Office/Free Standing Lab)                                                                                                                                 | \$0                                                                                                                             | 20%                                                                                                                  | \$0                                                                                                                             | 20%                                                                                                                      |
| Laboratory Testing (Outpatient Facility)                                                                                                                                                | \$0                                                                                                                             | 20%                                                                                                                  | \$0                                                                                                                             | 20%                                                                                                                      |
| X-rays                                                                                                                                                                                  | \$0                                                                                                                             | 20%                                                                                                                  | \$0                                                                                                                             | 20%                                                                                                                      |
| Advanced Radiology (MRI, MRA, PET, and CT)                                                                                                                                              | \$0                                                                                                                             | 20%                                                                                                                  | \$0                                                                                                                             | 20%                                                                                                                      |
| Rehabilitation Services                                                                                                                                                                 | In-Network                                                                                                                      | Out-of-Network                                                                                                       | In-Network                                                                                                                      | Out-of-Network                                                                                                           |
| Physical, Occupational, and Speech Therapy                                                                                                                                              | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Chiropractor Medicare Covered                                                                                                                                                           | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Acupuncture & Massage Therapy Annual Allowance                                                                                                                                          | \$500                                                                                                                           |                                                                                                                      | Not Covered                                                                                                                     |                                                                                                                          |
| Cardiac Rehab                                                                                                                                                                           | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Vision                                                                                                                                                                                  | In-Network                                                                                                                      | Out-of-Network                                                                                                       | In-Network                                                                                                                      | Out-of-Network                                                                                                           |
| Medical Vision Exam                                                                                                                                                                     | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Routine Vision Exam (Offered through Davis Vision)                                                                                                                                      | \$15                                                                                                                            | 20%                                                                                                                  | \$15                                                                                                                            | 20%                                                                                                                      |
| Annual allowance (lenses and frames) Offered through Davis Vision                                                                                                                       | \$200                                                                                                                           |                                                                                                                      | \$200                                                                                                                           |                                                                                                                          |
| Hearing                                                                                                                                                                                 | In-Network                                                                                                                      | Out-of-Network                                                                                                       | In-Network                                                                                                                      | Out-of-Network                                                                                                           |
| Diagnostic Hearing Exam                                                                                                                                                                 | \$15                                                                                                                            | 15%                                                                                                                  | \$15                                                                                                                            | 15%                                                                                                                      |
| Routine Hearing Exam (TruHearing)                                                                                                                                                       | \$45                                                                                                                            | \$45                                                                                                                 | \$45                                                                                                                            | \$45                                                                                                                     |
| Hearing Aid Benefit (TruHearing)                                                                                                                                                        | TruHearing: You pay a \$699 copay for the Advanced or a \$999 copay for the Premium hearing aid. Up to 2 hearing aids per year. | Not Applicable                                                                                                       | TruHearing: You pay a \$699 copay for the Advanced or a \$999 copay for the Premium hearing aid. Up to 2 hearing aids per year. | \$500 maximum allowance combined In and out-of-network towards hearing aids that are not the Advanced or Premium models. |
| Dental                                                                                                                                                                                  | \$200 Allowance                                                                                                                 |                                                                                                                      | \$200 Allowance                                                                                                                 |                                                                                                                          |
| Routine Dental                                                                                                                                                                          | \$200 Allowance                                                                                                                 |                                                                                                                      | \$200 Allowance                                                                                                                 |                                                                                                                          |
| Supplies, Equipment, and Devices                                                                                                                                                        | In-Network                                                                                                                      | Out-of-Network                                                                                                       | In-Network                                                                                                                      | Out-of-Network                                                                                                           |
| Durable Medical Equipment                                                                                                                                                               | \$0 compression stockings; \$0 all other items                                                                                  | 50%                                                                                                                  | \$0 compression stockings; \$0 all other items                                                                                  | 50%                                                                                                                      |
| Prosthetics                                                                                                                                                                             | \$0 diabetic shoes/inserts; \$0 all other items                                                                                 | 50%                                                                                                                  | \$0 diabetic shoes/inserts; \$0 all other items                                                                                 | 50%                                                                                                                      |
| Oxygen                                                                                                                                                                                  | 0%                                                                                                                              | 50%                                                                                                                  | 0%                                                                                                                              | 50%                                                                                                                      |
| Diabetic Supplies                                                                                                                                                                       | 0%                                                                                                                              | 20%                                                                                                                  | 0%                                                                                                                              | 20%                                                                                                                      |
| Fitness Program                                                                                                                                                                         | In-Network                                                                                                                      | Out-of-Network                                                                                                       | In-Network                                                                                                                      | Out-of-Network                                                                                                           |

| Highmark Fitness Program                                                                                                                                                             | Nationwide Fitness Network                                                                                                                                                                                                                            |                | Nationwide Fitness Network                                                                                                                                                                                                                            |                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| Part B Drugs                                                                                                                                                                         | In-Network                                                                                                                                                                                                                                            | Out-of-Network | In-Network                                                                                                                                                                                                                                            | Out-of-Network |
| Immunosuppressive Drugs                                                                                                                                                              | 0%                                                                                                                                                                                                                                                    | 0%             | 0%                                                                                                                                                                                                                                                    | 0%             |
| Oral Chemotherapy Drugs                                                                                                                                                              | 0%                                                                                                                                                                                                                                                    | 0%             | 0%                                                                                                                                                                                                                                                    | 0%             |
| Physician Administered Injectables                                                                                                                                                   | 0%                                                                                                                                                                                                                                                    | 0%             | 0%                                                                                                                                                                                                                                                    | 0%             |
| Nebulizer Inhalation                                                                                                                                                                 | 0%                                                                                                                                                                                                                                                    | 0%             | 0%                                                                                                                                                                                                                                                    | 0%             |
| Part B drugs (other)                                                                                                                                                                 | 0%                                                                                                                                                                                                                                                    | 0%             | 0%                                                                                                                                                                                                                                                    | 0%             |
| Value Added Rider                                                                                                                                                                    | In-Network                                                                                                                                                                                                                                            | Out-of-Network | In-Network                                                                                                                                                                                                                                            | Out-of-Network |
| Routine Chiropractic - These are routine/not medically necessary services that are not covered by Original Medicare. Chiropractic visits are limited to 12 visits per calendar year. | \$15                                                                                                                                                                                                                                                  | 20%            | \$15                                                                                                                                                                                                                                                  | 20%            |
| Routine Podiatry - These are routine/not medically necessary services that are not covered by Original Medicare. Podiatry visits are limited to 3 visits per calendar year.          | \$15                                                                                                                                                                                                                                                  | 20%            | \$15                                                                                                                                                                                                                                                  | 20%            |
| Meal Plan - 2 meals per day up to 7 days upon discharge from an Inpatient Hospital or SNF stay.                                                                                      | Covered for 1 meal per day up to 7 days                                                                                                                                                                                                               | Not Applicable | Covered up to 2 meals per day up to 7 days                                                                                                                                                                                                            | Not Applicable |
| Over the Counter Drug Allowance                                                                                                                                                      | Not Covered                                                                                                                                                                                                                                           | Not Applicable | Not Covered                                                                                                                                                                                                                                           | Not Applicable |
| Prescription Drugs - Part D                                                                                                                                                          |                                                                                                                                                                                                                                                       |                |                                                                                                                                                                                                                                                       |                |
| True Out of Pocket (TrOOP) Costs Threshold                                                                                                                                           | \$2,100                                                                                                                                                                                                                                               |                | \$2,400                                                                                                                                                                                                                                               |                |
| Formulary                                                                                                                                                                            | Fundamental                                                                                                                                                                                                                                           |                | Performance                                                                                                                                                                                                                                           |                |
| Medicare Excluded Part D Prescription Drug Rider                                                                                                                                     | Not Covered                                                                                                                                                                                                                                           |                | Not Covered                                                                                                                                                                                                                                           |                |
| Prescription Deductible                                                                                                                                                              | Not Applicable                                                                                                                                                                                                                                        |                | Not Applicable                                                                                                                                                                                                                                        |                |
| Retail Prescription Drugs (31 day supply)                                                                                                                                            | Preferred                                                                                                                                                                                                                                             | Standard       | Preferred                                                                                                                                                                                                                                             | Standard       |
| Tier 1 (Preferred Generic)                                                                                                                                                           | \$0.00                                                                                                                                                                                                                                                | \$5.00         | \$0.00                                                                                                                                                                                                                                                | \$5.00         |
| Tier 2 (Non-Preferred Generic)                                                                                                                                                       | \$5.00                                                                                                                                                                                                                                                | \$10.00        | \$5.00                                                                                                                                                                                                                                                | \$10.00        |
| Tier 3 (Preferred Brand & Generic)                                                                                                                                                   | \$10.00                                                                                                                                                                                                                                               | \$15.00        | \$10.00                                                                                                                                                                                                                                               | \$15.00        |
| Tier 4 (Non-Preferred)                                                                                                                                                               | \$25.00                                                                                                                                                                                                                                               | \$30.00        | \$25.00                                                                                                                                                                                                                                               | \$30.00        |
| Tier 5 (Specialty)                                                                                                                                                                   | \$25.00                                                                                                                                                                                                                                               | \$30.00        | \$25.00                                                                                                                                                                                                                                               | \$30.00        |
| Mail Order Prescription Drugs                                                                                                                                                        | Express Scripts                                                                                                                                                                                                                                       | Pharmacies     | Express Scripts                                                                                                                                                                                                                                       | Pharmacies     |
| Tier 1 (Preferred Generic)                                                                                                                                                           | \$0.00                                                                                                                                                                                                                                                | \$10.00        | \$0.00                                                                                                                                                                                                                                                | \$10.00        |
| Tier 2 (Non-Preferred Generic)                                                                                                                                                       | \$10.00                                                                                                                                                                                                                                               | \$20.00        | \$10.00                                                                                                                                                                                                                                               | \$20.00        |
| Tier 3 (Preferred Brand & Generic)                                                                                                                                                   | \$20.00                                                                                                                                                                                                                                               | \$30.00        | \$20.00                                                                                                                                                                                                                                               | \$30.00        |
| Tier 4 (Non-Preferred)                                                                                                                                                               | \$50.00                                                                                                                                                                                                                                               | \$60.00        | \$50.00                                                                                                                                                                                                                                               | \$60.00        |
| Tier 5 (Specialty)                                                                                                                                                                   | \$25.00                                                                                                                                                                                                                                               | \$30.00        | \$25.00                                                                                                                                                                                                                                               | \$30.00        |
| Retail and Mail Order Days Supply Limit                                                                                                                                              | <ul style="list-style-type: none"> <li>- Retail or Mail Order - Tier 1 &amp; 2 - Up to a 100 day supply</li> <li>- Retail or Mail Order - Tier 3 &amp; 4 - Up to a 90 day supply</li> <li>- Specialty Drugs are limited to a 31-day supply</li> </ul> |                | <ul style="list-style-type: none"> <li>- Retail or Mail Order - Tier 1 &amp; 2 - Up to a 100 day supply</li> <li>- Retail or Mail Order - Tier 3 &amp; 4 - Up to a 90 day supply</li> <li>- Specialty Drugs are limited to a 31-day supply</li> </ul> |                |
| Catastrophic Phase                                                                                                                                                                   | After reaching the True Out of Pocket (TrOOP) costs of \$2,100, 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.                         |                | After reaching the True Out of Pocket (TrOOP) costs of \$2,400, 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.                         |                |
| <b>Total Premium Per Member, Per Month</b>                                                                                                                                           | <b>\$477</b>                                                                                                                                                                                                                                          |                | <b>\$520</b>                                                                                                                                                                                                                                          |                |

This is a summary of the most commonly used benefits. It does not include a full list of benefits.

Please return to your local Markham Client Manager or fax to 1-833-841-8372

Signature

*Rachael France*

Date

9/29/2020

Printed Name

Rachael France

Title

District Treasurer

EGHP\_24\_3669\_M

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.

The Blue Shield(c) and Shield Symbol are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

TruHearing is a registered trademark of TruHearing, Inc., a separate company. Davis Vision is an independent company that provides the network and administers vision benefits for Highmark members. Express Scripts® is a separate company. Other

Pharmacies/Physicians/Providers are available in our network.

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

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6990 (TTY: 711)

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

我們提供免費的諮詢服務，以幫助您瞭解我們的醫療保險計劃。

**\*The premiums reflected on this document do NOT include the \$7.50 pcpm Amsure Fee\***