Because Highmark  keeping it simple.

Apply in 5 steps for your new 2022 individual/family Affordable Care Act (ACA) health plan with this application.

If you are applying because you have a Special Enrollment Period, please include this completed application along with the Special Enrollment Period form and all necessary, supporting documentation.

If you're enrolling during open enrollment, you can do this digitally. Just scan here.

HIGHMARK

5 steps to apply.

We're glad you're thinking of Highmark.

Let's make sure this is the application you need.

This application is for purchasing directly with Highmark, not if you're looking to purchase through the Pennsylvania Insurance Exchange (Pennie™). These plans don't apply federal premium tax credits or cost-sharing reductions. If you're not sure if you qualify for financial help, contact Pennie at Pennie.com or **1-844-844-8040**.

Other than that, you're eligible to enroll in these plans, regardless of your age as long as you meet these requirements:

- 0 You're not entitled to benefits under Medicare Part A, enrolled in benefits in Medicare Part B, or enrolled with CHIP.

- 0 You're currently living in the U.S..

- 0 You live in one of the counties listed on page 12 of this application and select a plan available in the county where you live.

- 0 You meet eligibility guidelines listed in Step 5 of this Application.

In the right place? Great.

There are a few kinds of plans you can apply to with this application. Here's a quick breakdown:

ACA Plans

These are your standard individual or family plans. You can read more about these on www.DiscoverHighmark.com/individuals-families or in the plan booklet. If you choose an HMO plan, everyone on your plan will be required to select an in-network primary care doctor — someone to provide preventive care and vaccines.

Conversion

If you lost your Highmark group plan and want to move to an individual plan, you might want a conversion plan. Find out more on page 15.

HIPAA

If you're losing your company's health plan and want a Highmark plan, a HIPAA plan might be for you. Find out more on page 16.

If you have any questions or want to enroll faster:

Call 1-855-957-5150.

Visit www.DiscoverHighmark.com.

Scan the QR code on the front if you're applying during open enrollment. If you're applying during a special enrollment period, we'll need you to complete the paper application.

Talk to your insurance agent/producer if you're working with one.

Or, we can help you in person at a **Highmark Direct store**. Find one near you at **HighmarkDirect.com**.

Instructions:
We've made this application as easy as possible with just 5 steps.

It might look like a lot, but these tips will make this application easier and avoid any processing delays.

- **Follow all 5 steps and make sure you fill everything in.** Once you finish a section, tear it out to send back to us.

- **Print letters and numbers clearly with blue or black ink.** If you're applying during open enrollment, you can fill out an electronic version of this form on www.DiscoverHighmark.com and print it.

- **If there's a box for your name at the bottom of a page,** make sure you fill it in. That helps us keep track of your application.

- **Sign and date the application on page 23** — If you are applying for coverage for yourself and your spouse/domestic partner, you both must sign this Application. If you are not married, under the age of 18, and applying for a policy that covers only you, a parent or guardian must sign this Application.

- **Tear out your completed application pages and return them to Highmark.** We'll outline all the ways you can do that on page 24.

Step 1: Tell us about you.

You + Highmark = one healthy 2022.

If you're applying for health insurance you need to complete the next page.

- **Page 6** — Everyone fills this page out with their personal information, even if applying for someone else like a minor child.
- **Page 8** — Fill out this page if you're applying for yourself and anyone else, you're applying on behalf of your dependents and you'll be the policy holder, or you're applying on behalf of a child under 18 for his or her own individual policy.

If you have limited English proficiency or a disability, call 1-800-876-7369 (TTY users can call 711) or visit a Highmark store to get assistance with this application free of charge.

64493

Step 1: Tell us about you.

And just a reminder to fill everything in clearly and mark "N/A" if you need to. Otherwise, the processing of this form might be delayed.

Some basics:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

– –

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

/ /

0 **Fill in this oval if you don't have a home address. You still need to give a mailing address where we can reach you.**

HOME ADDRESS

APARTMENT NUMBER

CITY, STATE, ZIP CODE

COUNTY

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)

APARTMENT NUMBER

CITY, STATE, ZIP CODE

COUNTY

HOME PHONE NUMBER (NON-MOBILE)

( ) -

MOBILE PHONE NUMBER

( ) -

PREFERRED CONTACT (SELECT ONLY ONE)

0 Home 0 Mobile

EMAIL ADDRESS

PREFERRED LANGUAGE SPOKEN (IF NOT ENGLISH)

PREFERRED LANGUAGE READ (IF NOT ENGLISH)

Who is this plan for?

Just fill in the oval that applies.

0 Just for you.

0 You and your family.

0 You're applying on behalf of a child under 18 for his or her own coverage as an individual policy holder.

Ahh, didn't that feel good?

All finished? Rip this page out.

64493

Step 1: About you continued.

HMO only:

Reminder: you'll need a Primary Care Provider for this kind of plan. If you need help with that, call **1-800-544-6679** or visit **HighmarkBCBS.com** and select **Find a doctor or pharmacy**.

PCP NAME

PCP ID NUMBER

Are you already a patient of this physician? 0 Yes 0 No

If you're 21 or older:

Just a few more questions if you're 21 or older and this plan is for you.

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last 6 months?

0 Yes 0 No

If yes, when was the last time you used tobacco regularly?

DATE (MM/DD/YYYY)

/ /

Communication preferences:

We can send you electronic communications consisting of email alerts and notifications, if you want. Those communications could include your agreement and outline of coverage, insurance plan notices, member newsletters, and health and wellness notices such as wellness, savings, and more. It'll be easier and faster to review. You can change this it at any time or request a digital copy by calling **1-800-544-6679** or visiting **HighmarkBCBS.com**.

So, what do you think?

0 **Yes,** let's do this digitally.

0 **Nah,** let's stick to paper.

Go to **HighmarkBCBS.com** to review the Contact Preferences Term and Conditions for complete details regarding selecting or changing communication preferences.

To ensure that you receive your member materials by your preferred method, you must notify Highmark if your phone number or email address change.

SOCIAL SECURITY OR TAX ID NUMBER

– –

APPLICANT'S LAST NAME

FIRST NAME

Step 1: Tell us about the rest of your family.

Just you? Go to page 12.

If you're applying for coverage for anyone else (let's call them dependents), fill their info in on this sheet. You can add more sheets if you need to.
Eligible dependents include:

- Your spouse or domestic partner
- Your children under the age of 26
- Your spouse or domestic partner's children under the age of 26

The plan and deductible option you choose will apply to everyone covered by your plan.

Dependent 1

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER – –

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY) / /

Does dependent 1 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

HMO only:

Remember: get help at **1-800-544-6679** or **HighmarkBCBS.com**.

PCP NAME

PCP ID NUMBER

Are you already a patient of this physician? 0 Yes 0 No

21 or older:

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last 6 months?

0 Yes 0 No

If yes, when was the last time you used tobacco regularly?

DATE (MM/DD/YYYY) / /

Room for more dependents on the next page.

SOCIAL SECURITY OR TAX ID NUMBER – –

APPLICANT'S LAST NAME

FIRST NAME

Step 1: Family continued.

Dependent 2

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

– –

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

/ /

Does dependent 2 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

HMO only:

Remember: get help at **1-800-544-6679** or **HighmarkBCBS.com**.

PCP NAME

PCP ID NUMBER

Are you already a patient of this physician? 0 Yes 0 No

21 or older:

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last 6 months?

0 Yes 0 No

If yes, when was the last time you used tobacco regularly?

DATE (MM/DD/YYYY)

/ /

Dependent 3

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

– –

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

/ /

Does dependent 3 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

HMO only:

Remember: get help at **1-800-544-6679** or **HighmarkBCBS.com**.

PCP NAME

PCP ID NUMBER

Are you already a patient of this physician? 0 Yes 0 No

21 or older:

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last 6 months?

0 Yes 0 No

If yes, when was the last time you used tobacco regularly?

DATE (MM/DD/YYYY)

/ /

SOCIAL SECURITY OR TAX ID NUMBER

– –

APPLICANT'S LAST NAME

FIRST NAME

Step 1: Family continued.

Dependent 4

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

– –

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

/ /

Does dependent 4 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

HMO only:

Remember: get help at **1-800-544-6679** or **HighmarkBCBS.com**.

PCP NAME

PCP ID NUMBER

Are you already a patient of this physician? 0 Yes 0 No

21 or older:

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last 6 months?

0 Yes 0 No

If yes, when was the last time you used tobacco regularly?

DATE (MM/DD/YYYY)

/ /

Dependent 5

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

– –

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

/ /

Does dependent 5 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

HMO only:

Remember: get help at **1-800-544-6679** or **HighmarkBCBS.com**.

PCP NAME

PCP ID NUMBER

Are you already a patient of this physician? 0 Yes 0 No

21 or older:

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last 6 months?

0 Yes 0 No

If yes, when was the last time you used tobacco regularly?

DATE (MM/DD/YYYY)

/ /

SOCIAL SECURITY OR TAX ID NUMBER

– –

APPLICANT'S LAST NAME

FIRST NAME

Step 1: Family continued.

Dependent 6

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

– –

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

/ /

Does dependent 2 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

HMO only:

Remember: get help at **1-800-544-6679** or **HighmarkBCBS.com**.

PCP NAME

PCP ID NUMBER

Are you already a patient of this physician? 0 Yes 0 No

21 or older:

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last 6 months?

0 Yes 0 No

If yes, when was the last time you used tobacco regularly?

DATE (MM/DD/YYYY)

/ /

Dependent 7

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

– –

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

/ /

Does dependent 2 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

HMO only:

Remember: get help at **1-800-544-6679** or **HighmarkBCBS.com**.

PCP NAME

PCP ID NUMBER

Are you already a patient of this physician? 0 Yes 0 No

21 or older:

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last 6 months?

0 Yes 0 No

If yes, when was the last time you used tobacco regularly?

DATE (MM/DD/YYYY)

/ /

SOCIAL SECURITY OR TAX ID NUMBER

– –

APPLICANT'S LAST NAME

FIRST NAME

Step 2: Find a plan.

Coverage that makes you  .

In this next step, you're going to select your plan. If you need any help with that, call **1-855-957-5150**.

Or, take a look through the plan brochure. All of the information you need is there.

You only need to fill out the page with the county you live in on it. If you're looking for a **HIPAA** or **Conversion** plan, go right to that page.

If you have limited English proficiency or a disability, call 1-800-876-7369
(TTY users can call 711) or visit a Highmark store to get assistance with this application free of charge.

Your county? Fill it out, rip it out.

Step 2: Find a plan in Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Pike, Sullivan, Susquehanna, Tioga, Wayne, or Wyoming counties.

Choose one plan and deductible option. **Fill in the oval next to the plan you've selected.** Your selection will apply to everyone covered by your plan.

These plans are just for Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Pike, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming counties.

Highmark Benefits Group - Group Number: 104654-17			Annual Deductible	
			Individual	Family
my Priority Blue Flex EPO	0	Premier Gold 0	$0	$0
	0	Premier Gold 0 + Adult Dental and Vision		
	0	Gold 0		
	0	Gold 0 + Adult Dental and Vision		
	0	Gold 1400 HSA	$1,400	$2,800
	0	Silver 2600	$2,600	$5,200
	0	Silver 2600 + Adult Dental and Vision		
	0	Silver 2900	$2,900	$5,800
	0	Silver 2900 + Adult Dental and Vision		
	0	Silver 3250 HSA	$3,250	$6,500
	0	Bronze 3800	$3,800	$7,600
	0	Bronze 3800 + Adult Dental and Vision		
	0	Bronze 6900 HSA	$6,900	$13,800
my Priority Blue EPO	0	Major Events EPO 8700 - 3 Free PCP Visits [Applicants must be under age 30 or have received an exemption certification from the Pennsylvania Insurance Exchange. Attach a copy of the certificate if you have one.]	$8,700	$17,400

Now, jump to page 19 to make your first payment.

Hooray. One step closer.

SOCIAL SECURITY OR TAX ID NUMBER – –

APPLICANT'S LAST NAME

FIRST NAME

Step 2: Find a plan in Monroe county.

Choose one plan and deductible option. **Fill in the oval next to the plan you've selected.** Your selection will apply to everyone covered by your plan.

These plans are just for Monroe county.

Highmark Benefits Group - Group Number: 104654-17			Annual Deductible	
			Individual	Family
my Priority Blue Flex EPO	0	Premier Gold 0	$0	$0
	0	Premier Gold 0 + Adult Dental and Vision		
	0	Gold 0		
	0	Gold 0 + Adult Dental and Vision		
	0	Gold 1400 HSA	$1,400	$2,800
	0	Silver 2600	$2,600	$5,200
	0	Silver 2600 + Adult Dental and Vision		
	0	Silver 2900	$2,900	$5,800
	0	Silver 2900 + Adult Dental and Vision		
	0	Silver 3250 HSA	$3,250	$6,500
	0	Bronze 3800	$3,800	$7,600
	0	Bronze 3800 + Adult Dental and Vision		
	0	Bronze 6900 HSA	$6,900	$13,800
my Priority Blue EPO	0	Major Events EPO 8700 - 3 Free PCP Visits [Applicants must be under age 30 or have received an exemption certification from the Pennsylvania Insurance Exchange. Attach a copy of the certificate if you have one.]	$8,700	$17,400

First Priority Health - Group Number: 017858-00			Annual Deductible	
			Individual	Family
my Lehigh Valley Flex Blue HMO	0	Gold 0	$0	$0

Now, jump to page 19 to make your first payment.

SOCIAL SECURITY OR TAX ID NUMBER – –

APPLICANT'S LAST NAME

FIRST NAME

Step 2: Find a Conversion plan.

Are you losing your Highmark group coverage and want to get Highmark individual coverage? Great, you may want a Conversion plan. It can start the day your group plan ends.

Choose one plan and deductible option. Fill in the oval next to the plan you've selected. Your selection will apply to everyone covered by your plan.

These plans are for residents of: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming counties.

Highmark Benefits Group - Group Number: 104654-17		Annual Deductible	
		Individual	Family
my Priority Blue Flex EPO	0 Bronze 3800	$3,800	$7,600

FIRST PREMIUM AMOUNT

$

Conversion Policy

EFFECTIVE FROM (MM/DD/YYYY):

/ /

EFFECTIVE TO (MM/DD/YYYY):

/ /

Now, jump to page 19 to make your first payment.

SOCIAL SECURITY OR TAX ID NUMBER

– –

APPLICANT'S LAST NAME

FIRST NAME

Step 2: Find a HIPAA plan.

Are you losing an employer's coverage and want to get a Highmark HIPAA (Health Insurance Portability and Accountability Act) plan? Welcome. Your plan can start when your current plan ends.

First, a few questions:

1. If your most recent coverage offered you "COBRA" or similar state required benefits, did you elect that coverage?

0 Yes 0 No

If YES, have you used up all your benefits under that coverage?

0 Yes 0 No

2. If you include your most recent coverage, have you had some type of creditable health care coverage continuously for at least 18 months?

0 Yes 0 No

*To find this, count periods of creditable coverage that you had before any breaks in coverage. Count them only if the break in coverage was less than 63 days. Do not count days during a waiting period when you had no coverage. Do not count days in a waiting period to determine if you had a break in coverage.

3. If you include your most recent coverage, have you had some type of creditable health care coverage continuously for at least 18 months?

0 Yes 0 No

4. Did your most recent health care coverage terminate because you did not pay your premium? This includes contributions or fraud.

0 Yes 0 No

Now, you need to **attach** your "Certificate of Prior Coverage" form to this application.

Don't have it?

Here are some other ways you can prove you had prior coverage:

1. Send us your signed written statement about your last coverage. Include names of the plans that covered you in the last 18 months and the beginning and end dates of coverage. Attach copies of papers proving that you had coverage during those times — something like an ID card, explanation of benefits, premium invoice, or paystubs proving you paid for health coverage. You must also cooperate with us to prove that you had coverage.
2. Complete and send us a HIPAA Prior Coverage Disclosure and Authorization Form instead of a written statement. You can get this form by calling Member Service at 1-800-544-6679.
3. Call us at 1-800-544-6679 to establish that you had coverage. Give us as much information as you can, then sign the form to let us contact your prior plans to prove that you had coverage.

SOCIAL SECURITY OR TAX ID NUMBER – –

APPLICANT'S LAST NAME

FIRST NAME

Next up, choose your HIPAA plan.

Choose one plan and deductible option. Fill in the oval next to the plan you've selected. Your selection will apply to everyone covered by your plan.

These plans are for residents of: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming counties

Highmark Benefits Group - Group Number: 104654-17			Annual Deductible	
			Individual	Family
my Priority Blue Flex EPO	O	Bronze 3800	$3,800	$7,600

APPLICATION DUE DATE (MM/DD/YYYY)

/ /

FIRST PREMIUM AMOUNT

$

HIPAA Policy

EFFECTIVE FROM (MM/DD/YYYY):

/ /

EFFECTIVE TO (MM/DD/YYYY):

/ /

Now, jump to page 19 to make your first payment.

SOCIAL SECURITY OR TAX ID NUMBER

– –

APPLICANT'S LAST NAME

FIRST NAME

Step 3: Your first payment.

The plan? Now, the check.

When you send this application in, you need to have your first premium payment included with it. We'll walk you through how to calculate that on the next page. If the first payment is not made with your application, your first premium payment will be due by the date printed on your first invoice.

Look at that, another check.

Step 3: Your first payment.

Start by filling in this information:

POLICY HOLDER NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY OR TAX ID NUMBER

Now grab your rate guide, or visit www.DiscoverHighmark.com.

Find the monthly premium for your plan based on the amount of people you listed in STEP 1 (that's you + any dependents you listed).

You'll need a check for that amount attached to this form, but fill the details of that check in below.

PAYMENT ENCLOSED

$

GROUP NUMBER

(Group number is the bold, blue eight-digit number; listed above plan selection.)

Once you receive your first invoice, you can head to **HighmarkBCBS.com** to sign up for automatic payments. Auto payments are a more secure and convenient way to pay your bill that eases any stress about making on time payments. Plus, you won't have to write more pesky checks like this one.

If you're applying for a Conversion or HIPAA plan and want your plan to start in the middle of the month, you'll need to prorate this first payment for the days remaining in the month your group coverage ended. You can figure that out like this:

Monthly premium divided by number of days in the month.

MONTHY PREMIUM $ ÷ DAYS IN THE MONTH = TOTAL

Then multiply that number by the number of days left in the month after your coverage starts.

TOTAL FROM ABOVE $ x DAYS LEFT IN THE MONTH = TOTAL

Call us for help with that 1-855-957-5150.

Done? Tear this out.

SOCIAL SECURITY OR TAX ID NUMBER – –

APPLICANT'S LAST NAME

FIRST NAME

Step 4: Current coverage.

The hard part is over.

Now we just need to know about any current health insurance you have (coverage you had for 2021).

Everyone fills this in:

1. **Are you or anyone else listed in Step 1** enrolled in a private or governmental group or individual health plan or program at the time of this application?

0 Yes 0 No

If YES, have you used up all your benefits under that coverage?

0 Yes 0 No

2. Is any person applying for this coverage entitled to benefits under Medicare Part A or enrolled in **Medicare Part B**?

0 Yes 0 No

If anyone listed in Step 1 is entitled to benefits under Medicare Part A or enrolled in Medicare Part B, you need to remove them. Those entitled to or enrolled in Medicare can't apply for benefits through this application. Learn more at **ssa.gov** or visit the nearest Social Security Administration office.

3. Is the coverage you're applying for **intended to replace** any accident or health insurance you or anyone in Step 1 currently have? This includes a Highmark policy.

0 Yes 0 No

SOCIAL SECURITY OR TAX ID NUMBER – –

APPLICANT'S LAST NAME

FIRST NAME

That was a great sound.

Step 4: Current coverage.

If you answered yes to 1, 2, or 3:

4. Tell us about any other coverage you and/or your family members have or have applied for:

NAME OF INSURANCE CARRIER

GROUP NUMBER

NAME OF POLICY HOLDER

EFFECTIVE DATE (MM/DD/YYYY)

/ /

POLICY NUMBER

RELATIONSHIP TO APPLICANT

POLICY HOLDER'S DATE OF BIRTH (MM/DD/YYYY)

/ /

POLICY HOLDER'S EMPLOYMENT STATUS

Everyone fills this in:

5. Will you or any of your family members who are applying for this coverage be receiving premium payment assistance or grants from a third party payer*?

0 Yes 0 No 0 Not Sure

If you answered Yes or I'm Not Sure, please indicate the type of third-party making payments to you or to Highmark on your behalf:

0 A family member

0 An Indian Tribe, tribal organization, or urban Indian organization

0 An employer

0 A local, State or Federal government program, including a grantee thereof

0 A Ryan White HIV/AIDS program

0 An IRS-recognized 501(c)(3) organization (nonprofit)

0 A health care provider or supplier

0 Other (please specify):

0 An Individual Coverage Health Reimbursement Arrangement (ICHRA)

EMPLOYER NAME:

0 A Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

EMPLOYER NAME:

*A third party payer would be any person, employer, organization or entity, that is paying all or some portion of your/your family's premium to Highmark, or directly to you/your family by means such as cash, check, money order, prepaid debit card, credit card or electronic fund transfers.

0 I/we acknowledge that I/we have an ongoing obligation to report to Highmark any changes relating to premium payment assistance or grants made by a third-party payer.

SOCIAL SECURITY OR TAX ID NUMBER

– –

APPLICANT'S LAST NAME

FIRST NAME

RIIIIPPPPPPPPP

Step 5: Your signature.

One last thing.

This is going to be a lot of legal language to read. Take a deep breath, you can do this. Once you read it, sign at the bottom to let us know that you agree.

Ready? Let's finish this.

You signed. Now seal and deliver.

Step 5: Your signature.

My/our signature on this Application indicates that I/we have read and fully understand the following statements:

I/we hereby apply for health care plan coverage for myself and/or my eligible dependents listed on this Application. I/we understand and agree that the terms and conditions of our coverage will be controlled by the written Subscription Agreement and that they may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of that Agreement, to administer the program. I/we recognize that our coverage will only apply to admissions that occur and services that are provided on or after the effective date of our coverage.

I/we understand that the Agreement is available only to residents of the geographic area in which the product for which this Application is completed is available and that this Application is subject to the provisions of this Agreement. This Agreement renews on an annual basis. **If the first payment is not made with this Application, the first premium payment is due by the due date printed on your first invoice.** Failure to pay before this due date will result in your Application being canceled. You can also pay your premium monthly in advance to Highmark. If it's convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis. These amounts will be subject to premium increases on the date the increase is effective.

I/we understand that the receipt of the benefits under this program is subject to the determination that the services were medically necessary and appropriate. Except for emergencies or delivery-related admissions, all inpatient admissions are subject to review prior to the proposed admission.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your ongoing monthly premium payments are not received in the full amount within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

If you are applying for a Conversion plan to cover you from the date your group plan ended or you are applying for a HIPAA plan to cover you from the date your employer plan ended, your final premium payment will include a prorated amount for the days remaining in the month your group coverage ended.

I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

I know that I must tell Highmark if any information I supplied on this Application changes. I must call 1-800-544-6679 to report any changes.

If your Application for other than HMO coverage is accepted, you agree to resolve any and all disputes, claims, or controversies arising out of or relating in any way to the Agreement that is issued or any service for which benefits are provided thereunder through binding arbitration rather than litigation in court. Your agreement to arbitrate applies to disputes between you and Highmark or any of Highmark's parents, subsidiaries, affiliates, officers, directors, employees, or agents. Any such disputes, claims, or controversies may only be brought individually and not in concert with other individuals who are not covered under the Agreement, unless otherwise agreed to by Highmark. Judgment may be entered on any arbitration award in any court having jurisdiction. The party filing arbitration may choose to file before JAMS, the American Arbitration Association, or any other organization or arbitrator mutually agreed to by the parties. Pennsylvania law will apply.

Effective Date Of Coverage

Your plan is effective based on the type of enrollment.

- **If you apply between November 1 and December 15,** your plan will begin January 1, 2022.If you apply between December 16 and January 15, your plan will begin February 1, 2022.
- **HIPAA or Conversion plans** will begin on the effective date marked on this application.
- **If you're applying during a Special Enrollment Period (SEP),** the effective plan date is based on the application laws for each eligible SEP.

To the best of my/our knowledge and belief, the information provided on this Application is true and correct. I also understand that any attempts to qualify for the program chosen through fraud or other intentional misrepresentation of a material fact will result in termination of such contract.

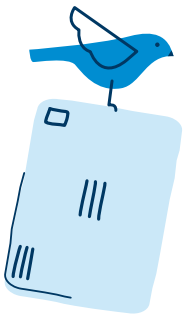
Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPLICANT'S SIGNATURE | DATE / /

SPOUSE/DOMESTIC PARTNER/PARENT'S SIGNATURE | DATE / /

NOTICE TO ALL APPLICANTS: If you are applying for coverage that includes your spouse or domestic partner, both you and your spouse/domestic partner must sign this Application form. If you are unmarried, under the age of 18, and applying for a policy that only covers yourself, your parent or guardian must sign. **This application is valid only when completed and signed by the applicant.**

One more time now.



Time to send this away.

Woohoo! You did it. You finished the application. Now, tear out the pages you completed and send them back to us. Here's a few ways to do that:

1 **By mail:**
Pack this completed, signed application into an envelope with a check for your first payment. If you live in any county except Monroe county, please send your payment to:

Highmark Benefits Group
c/o Highmark Blue Cross Blue Shield
PO Box 382555
Pittsburgh, PA 15250-8555

If you live in Monroe county and selected my Priority Blue Flex HMO Gold 0, include your completed, signed Application along with your first premium payment to:

First Priority Health
c/o Highmark Blue Cross Blue Shield
PO Box 382555
Pittsburgh, PA 15250-8555

2 **Drop it off with us:**
You can also bring this to a Highmark Insurance store. Find a location by visiting **HighmarkDirect.com.**

That's it, you're done! We can't wait to spend 2022 with you.

All done?
Double check these items to make sure your application isn't delayed:

- [ ] Make sure you've provided your full social security number
- [ ] If you have a group number, make sure it's filled in.
- [ ] Your check must be included with the application.

Discrimination is Against the Law

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

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

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

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

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-800-876-7639.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-800-876-7639 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-800-876-7639.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

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。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-800-876-7639 .

Only producers need to bother with this next section.
If you aren't a producer, you do not need to fill this page out.

Producers Certificate

If you have questions about completing this application, please call the Producer Line at 1-866-602-1248.
If this section is not fully completed, we will not pay a commission.

NATIONAL PRODUCER NUMBER (NPN)

PRODUCER'S NAME (LAST, FIRST, MIDDLE INITIAL)

AGENCY NAME

PRODUCER'S SIGNATURE

BUSINESS PHONE NUMBER

( ) -

A PRODUCER must complete this section to act on the applicant's behalf.

1. Consider how the applicant answered your questions. Do you know of any factors impacting the applicant's eligibility? What about his/her dependents applying for this coverage?

0 Yes 0 No

PRODUCER SIGNATURE

DATE

AGENCY

2. Have you provided the applicant with all relevant marketing materials?

0 Yes 0 No

3. Have you advised the applicant of the features of the product that he/she has selected, including satisfying his/her deductible(s)?

0 Yes 0 No

4. Is this applicant a current customer of Highmark?

0 Yes 0 No

5. Have you retained a signed copy of this application for your records?

0 Yes 0 No

Note: No producer may:

1. Accept risk or pass on any eligibility requirements;
2. Make or alter the terms of the Application or policy; or
3. Waive any of Highmark's rights or requirements.

HIGHMARK

Highmark Inc., d/b/a
Highmark Blue Cross Blue Shield
120 Fifth Avenue
Pittsburgh, PA 15222-3099

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Benefits Group, or First Priority Health all of which are independent licensees of the Blue Cross and Blue Shield Association.

Internal use only

NATIONAL PRODUCER NUMBER (NPN)

Notes

Notes

2022

is looking pretty great.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com or for a paper copy, call 1-855-873-4106.

09/21 MX483507 ENR-273F (3-21)