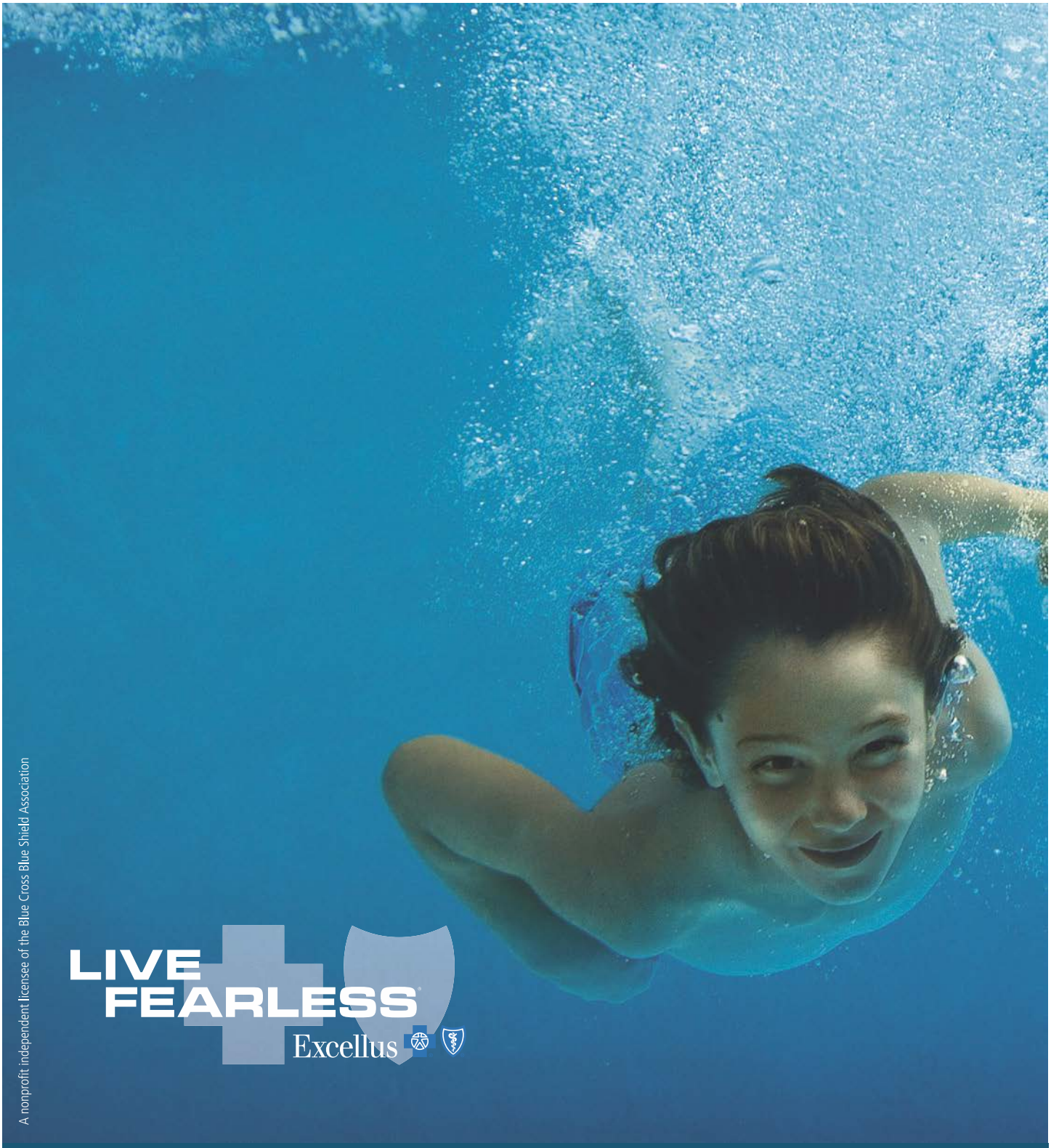


LIVE FEARLESS®

Excellus BlueCross BlueShield

A nonprofit independent licensee of the Blue Cross Blue Shield Association

YOUR BENEFIT PLAN DETAILS

Group Name
Cortland City Schools

Plan Type
Classic Blue w/ RX $5/$20/$40

Excellus BlueCross BlueShield makes finding the information and support you need easier—resources, savings, and tools are available online 24/7.

- Find a doctor or specialist online while you're home or far away.
- Research over 6,000 health topics.
- Get great member discounts and valuable information you can use all year long with Blue365®

Excellus

excellusbcbs.com

EBCBS - 08/10
4747-10M

Welcome

With Excellus BlueCross BlueShield, you get what you expect from Blue plus a whole lot more such as:

- More doctors, specialists, and hospitals to choose from
- Exclusive discounts on health-related products and services with Blue365®
- Answers to your health questions online
- Local customer service

In this booklet you will find:

- A chart that summarizes this plan's unique benefits and coverage*
- A glossary of terms to help you understand your coverage and options

We have many valuable benefits and we provide a tremendous amount of choice. Whichever plan you pick, we're ready to meet your health care needs.

Visit us at excellusbcbs.com

*This benefit summary is not a contract or binding agreement; it is a summary of benefits and services.

Privacy Policy Notice. We know how important your privacy is and we're committed to protecting it. Our policies and practices regarding the collection, use, and disclosure of personal health information are available at excellusbcbs.com and Member Services.

Cortland City Schools

Classic Blue w/ RX
$5/$20/$40

Plan Features

Primary Care Physician (PCP)	Not Required
Referrals	Not Required
Out of network benefits	Covered
Student / Dependent Coverage	Covered to age 26
Domestic Partner	Not Covered
Coverage Period	09/01/18-08/31/19
Office visit copay (Primary Care Physician)	20% Coinsurance subject to ded
Office visit copay (Specialist)	20% Coinsurance subject to ded
Coinsurance	20% Coinsurance
Deductible	$100 Individual/$300 Family
Out of pocket maximum	$2,500 Individual/$7,500 Family

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call or visit Our website at www.excellusbcbs.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$100 Individual/$300 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,500 Individual/$7,500 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Costs for penalties for failure to obtain preauthorization for services, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	20% Coinsurance	None
	Specialist visit	20% Coinsurance	20% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 Exam per year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: No Charge X-Ray: Deductible does not apply Blood Work: No Charge Blood Work: Deductible does not apply	X-Ray: No Charge X-Ray: Deductible does not apply Blood Work: No Charge Blood Work: Deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.excellusbcbs.com	Tier 1 (Generic drugs)	$5/prescription retail, $10/ prescription mail order Deductible does not apply	Not Covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription)
	Tier 2 (Preferred brand drugs)	$20/prescription retail, $40/ prescription mail order Deductible does not apply	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$40/prescription retail, $80/ prescription mail order Deductible does not apply	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Physician/surgeon fees	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need immediate medical attention	Emergency room care	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Emergency medical transportation	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Urgent care	No Charge Deductible does not apply	No Charge Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge Deductible does not apply	No Charge Deductible does not apply	None N/A None limit
	Physician/surgeon fees	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Inpatient services	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you are pregnant	Office visits	No Charge Deductible does not apply	No Charge Deductible does not apply	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Childbirth/delivery facility services	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need help recovering or have other special	Home health care	No Charge Deductible does not apply	No Charge Deductible does not apply	60 Visits per year limit

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
health needs	Rehabilitation services	20% Coinsurance	20% Coinsurance	100 Visits per year limit
	Habilitation services	20% Coinsurance	20% Coinsurance	100 Visits per year limit
	Skilled nursing care	No Charge Deductible does not apply	No Charge Deductible does not apply	100 Days per year limit
	Durable medical equipment	20% Coinsurance	20% Coinsurance	
	Hospice services	No Charge Deductible does not apply	No Charge Deductible does not apply	Family bereavement counseling limited to 5 Visits per year
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine eye care (Child)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

––––––––––––––––––––––To see examples of how this plan might cover costs for a sample medical situation, see the next section.––––––––––––––––––

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$100**
Coinsurance	**20%**
Hospital (facility) copayment	**$0**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$100**
Coinsurance	**20%**
Hospital (facility) copayment	**$0**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$90
Coinsurance	$120
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$370**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$100**
Coinsurance	**20%**
Hospital (facility) copayment	**$0**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$110
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$210**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

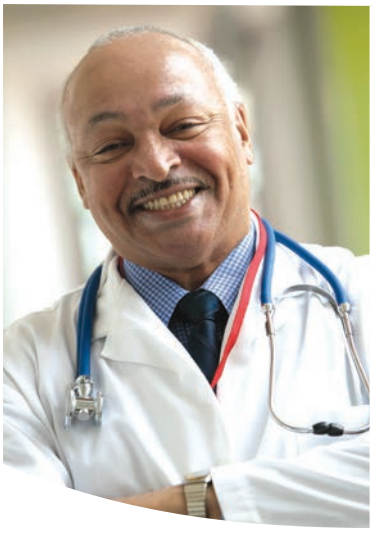
Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

B-5495

Find a Doctor or Specialist



Excellus BlueCross BlueShield is part of a network of BlueCross BlueShield Plans that make up the largest group of Participation Doctors and Specialists in the world. With that you get cost effective quality health care whenever you need it.

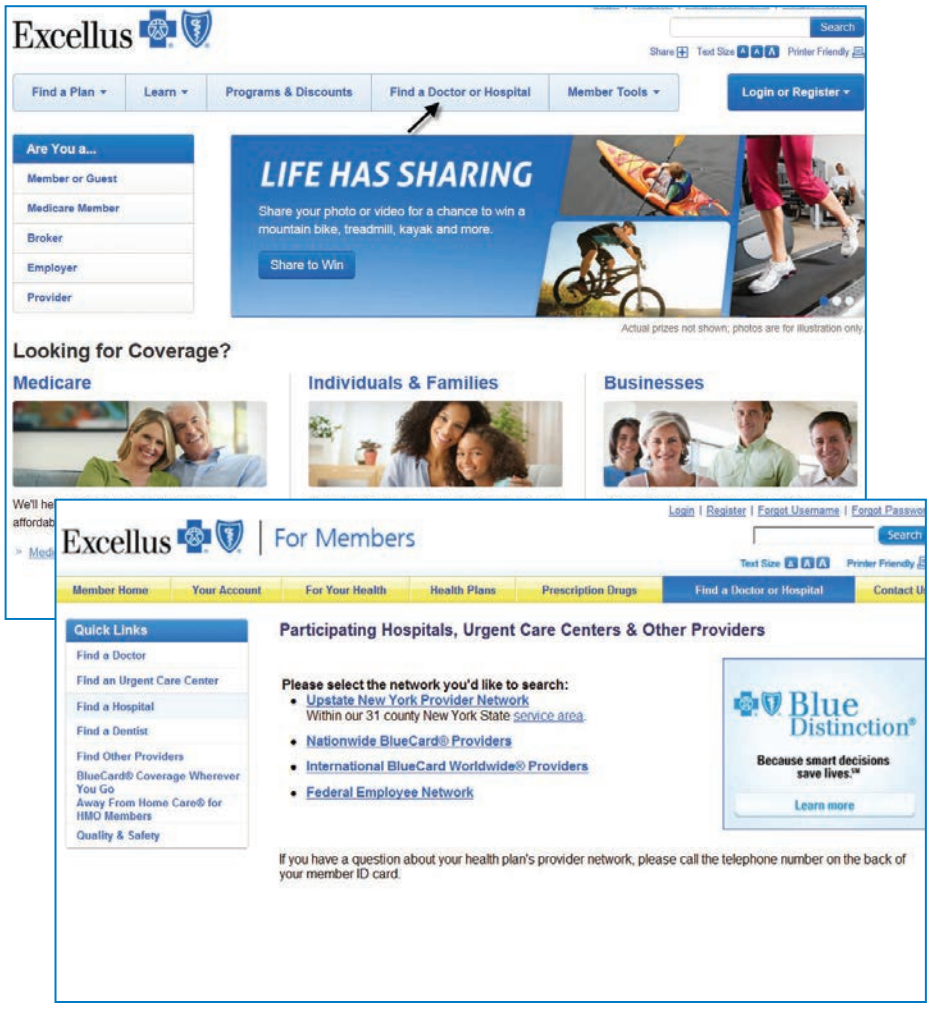
Our online provider directory makes it easy to search for providers by:

- Name
- Zip code
- Gender
- Languages spoken
- Accepting new patients
- Hospital affiliation

Results include:

- Office hours
- Locations
- Phone numbers
- Map & Directions
- Handicap Accessibility

Just look over our alphabetical listing online at ExcellusBCBS.com/FindProvider



ExcellusBCBS.com/FindProvider

Welcome to Blue365

Where taking care of yourself is an everyday thing.

Take advantage of healthy deals and discounts* on fitness, healthy eating, personal care and more that you can use all year long. Explore all the healthy choices at ExcellusBCBS.com/Blue365

Blue365® is here for you.

We understand that helping you live a healthy life means more than regular doctor visits - it's helping you find time for the things that matter most.

That's why we created Blue365, an online destination featuring healthy deals and discounts exclusively for our members. These "Blue365 Deals" which complement your health care coverage, can help you maintain a healthy lifestyle, while spending less at some of your favorite Blue365 vendors nationwide.

Because of the Blues' buying power, Blue365 can offer access to great savings on a wide range of exciting health and wellness products and experiences.

Blue365 makes it easy for you to find out about weekly "Featured Deals" by sending the news right to your email. Our email service is free to members of participating local Blue Companies.

All you have to do is register on the website, and you are all set to enjoy our great health and wellness deals.

You'll see weekly "Featured Deals" and long term "Ongoing Deals" on health products, along with discounts on health and fitness clubs, weight-loss programs, healthy travel experiences and so much more.

Blue365

Blue365 includes offers from selected companies based on feedback from Blue365 members and independent researchers on the Blue365 team. Examples include:

Fitness: Save on membership, monthly fees and other services at Healthways, Snap Fitness™, Reebok®, and Polar®.

Healthy Eating: Save on programs, products and consultations at Jenny Craig®, Dole® and Nutrisystems®.

Living: Save on services from Quicken Loans®.

Personal Care: Save on products and services from TruHearing, Beltone®, LasikPlus®, Davis Vision® and Dental Solutions.

* Discounts are available through independent companies that do not provide Blue Cross and/or Blue Shield products or services and are solely responsible for the services provided. See our website for more information at: ExcellusBCS.com/Blue365. The content, tools and discounted offers available through Blue365 are subject to change. Please visit ExcellusBCS.com/Blue365 for the most current program details.

Blue365®
Because health is a big deal℠

Healthcare Coverage Wherever You Go

As a Blue℠ member, you have more freedom to choose the doctors and hospitals that best suit you and your family. Your membership gives you a world of choices. Within the United States, you're covered whether you need care in urban or rural areas. Outside of the United States, you have access to doctors and hospitals in more than 200 countries and territories around the world through the BlueCard Worldwide® Program.

With the BlueCard Program, you can locate doctors and hospitals quickly and easily. With your Blue Plan ID card handy, follow these steps:

- Visit the Blue National Doctor & Hospital Finder at www.BCBS.com to locate doctors and hospitals, along with maps and directions to find them.
- Blue Cross and Blue Shield Association launched a Blue National Doctor and Hospital Finder app for iPhone, iPad and iPod Touch, allowing you to quickly search for healthcare providers nationwide. There is no charge to download the app from the App Store, but rates from your wireless provider may apply.
- BlueCard Access at 1.800.810.BLUE (2583) for the names and addresses of doctors and hospitals in the area where you or a covered dependent need care.

If you're a PPO member, always use a BlueCard PPO doctor or hospital to ensure you receive the highest level of benefits.

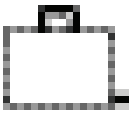
Designed to save you money.

In most cases, when you travel or live outside your Blue Plan's service area, you can take advantage of savings the local Blue Plan has negotiated with its doctors and hospitals. For covered services, you should not have to pay any amount above these negotiated rates and any applicable out-of-pocket expenses.

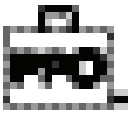
Take charge of your health, wherever you are.

Within the United States

1. Always carry your current Blue ID card.
2. To find nearby doctors and hospitals, call BlueCard Access at 1.800.810.BLUE (2583) or visit the Blue National Doctor & Hospital Finder at www.BCBS.com.
3. Call your Blue Plan for precertification or prior authorization, if necessary. Refer to the phone number located on your Blue ID card. Note: This phone number is different from the BlueCard Access number mentioned above.
4. When you arrive at the participating doctor's office or hospital, show the provider your ID card. The provider will identify your benefit level through one of these symbols:



Traditional/ Indemnity Benefits



PPO Benefits

After you receive care, you should:

- Not have to complete any claim forms.
- Not have to pay upfront for medical services, except for the usual out-of-pocket expenses (noncovered services,deductible, copayment and coinsurance).
- Receive an explanation of benefits from your Blue Plan.

In an emergency, go directly to the nearest hospital.

BlueCard Program

Around the world

1. Verify your international benefits with your Blue Plan before leaving the United States as coverage may be different outside the country.
2. Always carry your current Blue ID card.
3. If you need to locate a doctor or hospital, or need medical assistance services, call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.
4. Please see below for the steps that should be taken for inpatient and professional services.

   Inpatient claim: Call the BlueCard Worldwide Service Center at 1.800.810.2583 or collect at 1.804.673.1177 when you need inpatient care. In most cases, you should not need to pay upfront for inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket expenses (non covered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf. In addition to contacting the BlueCard Worldwide Service Center, call your Blue Plan for precertification or preauthorization. Refer to the phone number on your Blue ID card. Note: this number is different from the phone number listed above.

   Professional claim: You pay upfront for care received from a doctor and/or non-participating hospital. Complete a BlueCard Worldwide International claim form and send it with the bill(s) to the BlueCard Worldwide Service Center (the address is on the form). The claim form is available from your Blue Plan, the BlueCard Worldwide Service Center, or online at BCBS.com/bluecardworldwide.

Prevention is the best medicine

Preventive health can help you and your family stay healthy and prevent disease. Preventive care includes immunizations, also known as vaccines. They are safe and effective.

The following vaccines are especially important to consider. The information is based on recommendations from the Centers for Disease Control and Prevention. For more information and a complete listing of recommended vaccines visit the CDC website at cdc.gov/vaccines.

Tdap:

This vaccine protects against tetanus, diphtheria and pertussis (whooping cough). Immunity to whooping cough wears off over time, so one dose of Tdap to replace one TD booster is recommended for those ages 11 and older, including adults age 65 and older

In response to a recent spike in the number of Pertussis cases, the CDC and the American Academy of Pediatrics recommend that women get a booster dose of Tdap vaccine during each pregnancy, ideally between 27 and 36 weeks, regardless of previous Tdap history. If not administered during pregnancy, Tdap should be administered immediately postpartum.

Varicella (chicken pox), MMR (measles, mumps and rubella), Hepatitis A and Hepatitis B vaccines:

These vaccines are needed for adults who did not have these diseases or vaccines when they were children. Talk to your health care provider to determine if you need updates.

HPV:

HPV (human papillomavirus) vaccine is important because it can help prevent cases of cervical cancer in females if given before exposure to the virus. It may be given to males and females. It is recommended to be given starting at approximately age 11 years, and can be administered up to age 26 years. Talk to your child's doctor about your child having the HPV vaccine.

Meningococcal:

Meningococcal disease is a serious bacterial illness. Meningitis is an infection of the covering of the brain and the spinal cord. Adolescents and those with certain health conditions should be routinely immunized with the meningitis vaccine. Speak with your health care provider to learn more about this important vaccine.

Flu:

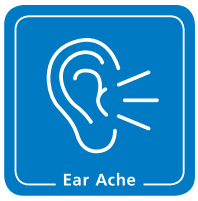
Flu vaccine is recommended for everyone older than 6 months. The best results for children ages 6 months through 8 years are two doses given four weeks apart if receiving the flu vaccine for the first time.

Pneumonia:

Infants, very young children and older persons are at highest risk for complications from pneumonia. It is recommended that those with chronic health conditions receive a pneumonia vaccine. Talk to your doctor about the benefit of a pneumonia vaccine.

Visit ExcellusBCBS.com/StayHealthy for more information on immunizations, age-appropriate health screenings and more.

When to go to an Urgent Care



Urgent Care is convenient care.

When a medical issue doesn't require an Emergency Room visit, or if you can't get in to see your physician, you can visit an Urgent Care Center and get the care you need.

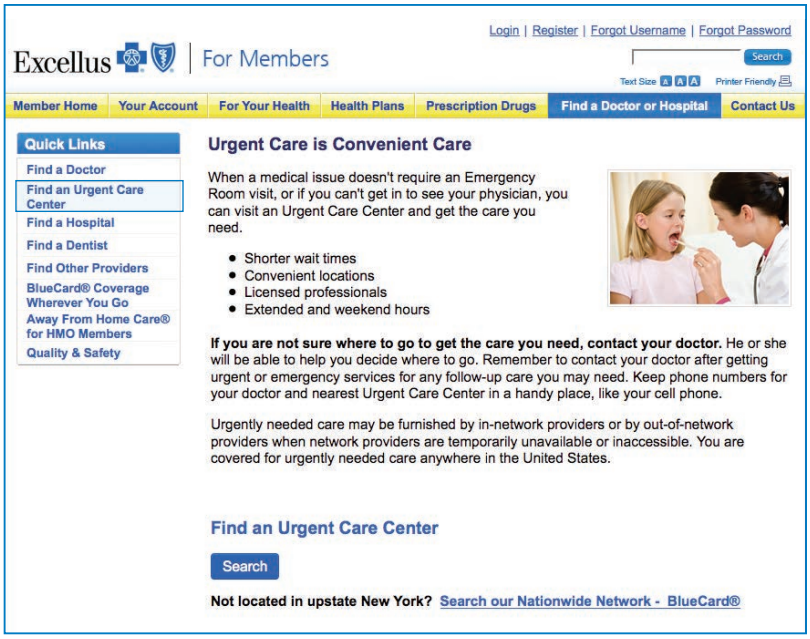
- Shorter wait times
- Licensed professionals
- Convenient locations
- Extended and weekend hours

If you are not sure where to go to get the care you need, contact your doctor.

He or she will be able to help you decide where to go. Remember to contact your doctor after getting urgent or emergency services for any follow-up care you may need

Keep the number of your doctor and your nearest Urgent Care Center in an easy-access place, like your cell phone

ExcellusBCBS.com/FindProvider



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Important Facts Regarding Your Authorization to Share Protected Health Information

- In order to comply with Federal HIPAA regulations health plans must obtain a member's permission to share his/her protected health information with any other person. There are limited exceptions to this.

- As permitted by law, we will continue to communicate to providers of care involved in your treatment: (1) our payment activities in connection with your claims, (2) your enrollment in our health plan and (3) your eligibility for benefits.

- Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information for sexually transmitted diseases, abortion, and drug or alcohol abuse unless the child specifically authorizes the release of such information.

- This form is used to authorize us to share your protected health information. Each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period.

- We will NOT disclose information relating to genetic testing, substance use disorder, mental health, abortion, and sexually transmitted disease information unless you initial the corresponding condition in Part D. If you would like to authorize us to release information regarding HIV/AIDS, New York State requires that a different form be completed. To obtain a copy of this form, please contact our office at the telephone number listed on your identification card, or access the form at the following website: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm.

- If you need additional forms, you may copy this form, contact our office at the telephone number listed on your identification card or visit our Web site at https://www.excellusbcbs.com and search for "Manage Your Privacy".

- Please ensure you have fully completed the form so that we may honor your request.

RETAIN A COPY FOR YOUR RECORDS

AUTHORIZATION TO EXCELLUS HEALTH PLAN, INC. ("HEALTH PLAN") TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

☐ **Check here only if you are authorizing access to psychotherapy notes. If checked, this form cannot be used for any other purpose. You must complete a separate form for authorizing access to any other information. If this box is checked, skip Part D.**

PLEASE PRINT

PART A: MEMBER/INDIVIDUAL WHO IS THE SUBJECT OF THE INFORMATION TO BE DISCLOSED

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION # - located on ID card(s)

CURRENT ADDRESS	CITY	STATE/ZIP CODE

PART B: HEALTH PLAN CAN SHARE MY INFORMATION WITH THE FOLLOWING PERSON(S)

NAME OF PERSON/ORGANIZATION	ADDRESS
NAME OF PERSON/ORGANIZATION	ADDRESS

PART C: REASON FOR MEMBER/INDIVIDUAL (PART A) AUTHORIZING DISCLOSURE

☐ At my request ☐ Other: _____

PART D: HEALTH PLAN CAN SHARE THE FOLLOWING INFORMATION *(select D-1 **or** D-2 and if applicable, D-3)*

NOTE: Skip this section if psychotherapy was checked at the top of this form

D-1. ☐ I would like you to disclose any information requested by the person or entity named in Part B. This includes information in Part D-3 (below) only if I placed my initials next to the condition. If my initials do not appear in D-3, information related to those conditions will not be disclosed.

- OR –

D-2. I would like to limit the disclosure of information to a specific type of information, provider, condition or date(s). If this area is blank I do not wish to limit the disclosure of my information.

☐ Enrollment *(e.g. eligibility, address, dependents, birth date)*
☐ Benefit *(e.g. benefit coverage, usage, limits)*
☐ Claim *(e.g. status, provider, dates, payment, diagnosis)*
☐ Clinical records *(e.g. doctor/facility, case management)*
☐ Other limitation: _____
☐ Date Range _____ to _____

- AND, IF APPLICABLE -

D-3. Unless specifically indicated below, information will not be disclosed related to the following conditions. If I have placed my initials next to one or more of these conditions, the Health Plan is authorized to disclose information related to those conditions.

____ Genetic testing
____ Sexually transmitted diseases
____ Substance use disorder
____ Abortion
____ Mental health *(excluding psychotherapy notes)*

Note: A separate form must be completed in order to authorize release of information related to HIV/AIDS. The NYS approved form can be found at http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm

CONTINUED ON THE NEXT PAGE

PART E: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

I understand that:

- I can revoke this authorization at any time by writing to the Health Plan at the address listed below except this revocation would not affect any action taken by the Health Plan in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.
- Health Plan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on my giving this authorization.
- Unless you receive revocation in writing, this authorization will be valid until the date specified here: _____

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form.

Signature: _____ Date: _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: _____

Personal Representative Signature _____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other * _____

** You must provide documentation supporting your legal authority to act on behalf of the member*

RETURN TO:

Excellus Health Plan
P.O. Box 21146
Eagan, MN 55121

or Fax: 315-671-7079

Please keep a copy for your records

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's 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, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

Type of Care/Plan Benefits	Coverage
Plan features	
. Primary Care Physician (PCP)	• No copay, office visit covered subject to deductible and coinsurance
. Referrals	• Not required
. Out of network benefits	• Covered
. Out of area benefits	• Coverage provided worldwide through the BlueCard program.
. Student/Dependent coverage	• Qualified dependents and students are covered to age 26.
. Domestic partner	• Not covered
Plan cost-sharing highlights	
. Office visit copay (Primary Care Physician)	• No copay, office visit covered subject to deductible and coinsurance
. Office visit copay (Specialist)	• No copay, office visit covered subject to deductible and coinsurance
. Coinsurance	• 20%, enhanced benefits only, unless noted
. Deductible	• $100 individual / $300 family, enhanced benefits only
. Annual coinsurance maximum	• $400 individual / $1200 family, enhanced benefits only
. Annual pharmacy maximum	• $2000 individual / $6000 family

type of care/plan benefits	Coverage
Wellness Incentive	
. Stay healthy with great programs and incentives!	• Blue365 - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids.
Preventive Health Care Services	
. Well child visits	• Covered in full
. Adult routine physical exams	• Covered in full for 1 exam per year
. Adult immunizations	• Covered in full
. Mammography	• Covered in full
. Pap smear	• Covered in full
. Routine GYN exam	• Covered in full
. Prostate cancer screening	• Covered in full
. Routine vision	• Not covered
. Colonoscopy	• Covered in full
Physician Office Services	
. Diagnostic office visits	• Subject to deductible and coinsurance
. Diagnostic x-rays	• Covered in full
. Diagnostic laboratory and pathology	• Covered in full
. Allergy tests	• Subject to deductible and coinsurance
. Allergy injections	• Subject to the deductible and coinsurance
. Chemotherapy	• Covered in full
. Radiation therapy	• Covered in full
Maternity Services	
. Prenatal and postpartum care	• Covered in full
. Hospital care for mom (including delivery)	• Covered in full
. Newborn nursery care	• Covered in full
Prescription Drug	

continued

Type of Care/Plan Benefits	Coverage
• **Short-term and maintenance drugs are covered up to a 30-day supply at participating retail pharmacies; 90-day supply (subject to two copays per 90-day supply) is available through Express Scripts mail order pharmacy. Contraceptives included.**	• $10/$25/$40
Inpatient Hospital Benefits	
• **Hospital benefits**	• Covered in full for unlimited days
• **Physician visits in the hospital**	• Covered in full
• **Inpatient physical rehabilitation**	• Covered in full for 30 days. After basic benefits exhausted, not subject to deductible and coinsurance for unlimited days
• **Surgery**	• Covered in full
• **Anesthesia**	• Covered in full
Emergency Care	
• **Emergency room care**	• Covered in full
• **Freestanding urgent care center**	• Covered in full
• **Ambulance**	• Covered in full
Outpatient Hospital Benefits	
• **Diagnostic x-rays**	• Covered in full
• **Diagnostic laboratory and pathology**	• Covered in full
• **Surgical care**	• Covered in full
• **Chemotherapy**	• Covered in full
• **Radiation therapy**	• Covered in full
Mental Health and Chemical Dependence	
• **Inpatient mental health care**	• Covered in full for unlimited days
• **Outpatient mental health care**	• Covered in full for unlimited visits
• **Inpatient chemical dependence**	• Covered in full for unlimited days
• **Outpatient chemical dependence**	• Covered in full for unlimited visits
Other Services	
• **Diabetic insulin and supplies**	• Covered in Full
• **Skilled nursing facility**	• Covered in full for 100 days. After basic benefits exhausted, not subject to deductible and coinsurance for unlimited days
• **Home care**	• Covered in full for up to 60 visits per year. Subject to deductible and coinsurance after basic benefits have exhausted for up to 325 visits per year
• **Hospice**	• Covered in full for unlimited days
• **Outpatient therapy**	• Subject to deductible and coinsurance, limited to 100 visits per calendar year
• **Durable medical equipment**	• Subject to deductible and coinsurance
• **External prosthetics**	• Subject to deductible and coinsurance
• **Chiropractic**	• Subject to deductible and coinsurance
• **Acupuncture**	• Not covered
• **Dental**	• Not covered
• **Hearing**	• Not covered

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GROUP ENROLLMENT FORM

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Instructions on last page. All Dates = mm/dd/yy

PLEASE PRINT CLEARLY

1 – Group Employer Information

This section should be completed by the Group Benefits Administrator.
This application cannot be processed without this information and a signature.

Please use blue or black ink, print one character per box

Group # 0 0 0 6 3 2 2 5

Subgroup # ☐☐☐☐ Class# ☐☐☐☐

Employer Name: **CORTLAND CITY SCHOOLS**

Association/Chamber Name (if applicable): **COOPERATIVE HEALTH INSURANCE FUND**

Group Administrator Signature/Date: **X**

Dental Group # ☐☐☐☐☐☐ Subgroup # ☐☐☐

Subscriber Status: ☐ Active ☐ Retired ☐ COBRA ☐ Cancelled

Please indicate reason for COBRA:

☐ Left Employ/Retirement ☐ Death of Spouse
☐ Divorce/Legal Separation ☐ Dependent Reached Max Age
☐ Loss of Student Status ☐ Other ___________

Effective Date ☐☐☐☐☐☐ COBRA Effective Date ☐☐☐☐☐☐

Hire/Rehire Date ☐☐☐☐☐☐ Retired Effective Date ☐☐☐☐☐☐

Was the employee subject to a waiting period before enrolling in your employer health plan? ☐ No ☐ Yes

If yes, what was the start date: ☐☐☐☐☐☐ and end date ☐☐☐☐☐☐

2 – Subscriber Plan Selection

Department # ☐☐☐☐☐☐☐☐ Employee # ☐☐☐☐☐☐☐☐☐☐

Please use blue or black ink, print one character per box. Check applicable plan(s).

❑ Classic Blue (BXU)
❑ Classic Blue (BXV)
❑ Classic Blue (BXW)
❑ Classic Blue (BXX)
❑ Classic Blue (CCZ)

Please check coverage type and person(s) to be covered:

☐ Medical ☐ single ☐ sub & spouse ☐ sub & dependent(s) ☐ family
☐ Dental ☐ single ☐ sub & spouse ☐ sub & dependent(s) ☐ family

Dental
❑ Dental (DE)

3 – Reason for Enrollment/Change

Subscriber, please indicate the reason for this enrollment or change.

☐ New Hire ☐ COBRA ☐ Retirement ☐ Loss of Coverage ☐ Domestic Partner
☐ Open Enrollment ☐ Address/Phone Number ☐ Last Name ☐ Age 65+ ☐ Remove Dependent ☐ Change in Student Status
☐ Medicare Eligible / Please indicate reason for Medicare eligibility: ☐ Newborn ☐ Disability ☐ End Stage Renal Disease
☐ Add Dependent / Please indicate reason for adding dependent: ☐ Adoption ☐ Marriage ☐ Marital Status Change

4 – Subscriber Information

Please complete both sides of this application.
The subscriber signature is required in order to process the application.

Subscriber's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Subscriber's First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

MI ☐ Title ☐☐☐ E-mail Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Mailing Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Apt or Suite ☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐ Zip ☐☐☐☐☐

Work Phone Number ☐☐☐-☐☐☐-☐☐☐☐ / Home Phone Number ☐☐☐-☐☐☐-☐☐☐☐ / Cell Phone Number ☐☐☐-☐☐☐-☐☐☐☐

Date of Birth Gender Social Security Number

☐☐☐☐☐☐ ☐ M ☐ F ☐☐☐-☐☐-☐☐☐☐

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced/ Marital Status Event Date ☐☐☐☐☐☐

Medicare Number (if applicable) Part A Effective Date Part B Effective Date

☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐ ☐☐☐☐☐☐

If Medicare eligible due to ESRD please check type of dialysis: ☐ Self administered ☐ Facilitated Date started ☐☐☐☐☐☐

5 – Other Coverage Information Have you ever been a member of Excellus BlueCross BlueShield? ☐ Yes ☐ No

In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.

Have you, your spouse or any enrolled dependent had other coverage within the last 63 days? Health? ☐ No ☐ Yes / Dental? ☐ No ☐ Yes

If answering "Yes", are you keeping the additional health and/or dental coverage? Health? ☐ No ☐ Yes / Dental? ☐ No ☐ Yes

Who did the other plan cover? ☐ Self ☐ Spouse ☐ Children

Other insurance carrier name:

Other insurance name of policyholder:

Policy ID Number: Effective Date Termination Date

☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐ ☐☐☐☐☐☐

6 – Cancellation Information

Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).

Subscriber ☐ Medical ☐ Dental / Reason_____ Date ☐☐☐☐☐☐

Dependent (list each dependent in section 7) ☐ Medical ☐ Dental / Reason _____ Date ☐☐☐☐☐☐

7 – Dependent Information

Please provide all information for each person to be covered.

Subscriber's Last Name Subscriber's First Name

Spouse/Domestic Partner Last Name Spouse/Domestic Partner First Name M.I.

☐ Male ☐ Female Date of Birth ☐☐☐☐☐☐ Social Security Number ☐☐☐-☐☐-☐☐☐☐ Are you enrolling as a Domestic Partner? ☐ Yes ☐ No

Medicare Number (if applicable) Part A Effective Date Part B Effective Date

☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐ ☐☐☐☐☐☐

8 – Release/Signature

Subscriber signature required. You must sign and date this form to be eligible for insurance.

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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature_____**Date**_____

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Instructions on last page. All Dates = mm/dd/yy

PLEASE PRINT CLEARLY

9 – Additional Dependents

Please provide all information for each person to be covered.

Subscriber's Last Name | Subscriber's First Name

Dependent's Last Name | Dependent's First Name | M.I.

☐ Male ☐ Female | Date of Birth | Social Security Number | Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No (See last page for additional information)

Is Dependent a full time student? ☐ No ☐ Yes If yes, please indicate college/university name:

College/University Name | Expected Graduation Date | Credit hours

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Dependent's Last Name | Dependent's First Name | M.I.

☐ Male ☐ Female | Date of Birth | Social Security Number | Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No (See last page for additional information)

Is Dependent a full time student? ☐ No ☐ Yes If yes, please indicate college/university name:

College/University Name | Expected Graduation Date | Credit hours

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Dependent's Last Name | Dependent's First Name | M.I.

☐ Male ☐ Female | Date of Birth | Social Security Number | Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No (See last page for additional information)

Is Dependent a full time student? ☐ No ☐ Yes If yes, please indicate college/university name:

College/University Name | Expected Graduation Date | Credit hours

Instruction Page

Reason for Enrollment/Change: Check the appropriate action in the space provided. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator/Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you must also check coverage type and persons to be covered, and Dependent Information section.

Cancel Request
To process a Subscriber or Dependent cancellation, please use the Membership Cancellation Worksheet - OR -

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

Left Employer/No Longer Eligible
Commercial
COBRA Begin Date
COBRA Handicapped/Disabled Date
Transfer to Traditional
Transfer to HMO
Transfer to POS
COBRA End Date
Subscriber Request
Subscriber Deceased
Spouse's Insurance
Medicaid
Medicare

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Dependent Name and Dependent Birth date

Cancel Dependent Reasons

Marriage – when permitted by law
Dependent Over Age
Deceased
Ineligible Student
COBRA Begin Date
Subscriber Request
Divorce
Medicare

COVERAGE TYPE All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

FAMILY MEMBER INFORMATION If there are more than four dependents please use an additional form.
QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the eligible child age for your employer group:
  - natural, adopted or stepchild
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.

  Dependents pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age for your employer group.

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

GROUP EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical/Dental) that is applicable to the employee's request.

If you have any questions, please contact your Group Administrator/Representative.

Or, visit:

www.excellusbcbs.com/cnycoop

Health plan terms

To help you better understand our plans and your coverage, here are a few definitions* for frequently used health care terms.

Primary Care Physician (PCP)—A doctor who serves as your health care manager and coordinates virtually all of the health care services you routinely receive. Some plans do not require you to choose a PCP.

Referral—Instructions provided by a PCP for specialty care. Most plans do not require referrals.

In-network coverage—The coverage available when you receive services from a provider who participates in your health plan.

Out-of-network coverage—The coverage available when you receive services from a provider who does not participate in your health plan. Some plans may not include out-of-network coverage.

Out-of-area—Describes when you receive services while outside the geographic service area of your health plan. Your plan benefits may differ if you live or work beyond the geographic service area.

Copay—A dollar amount due at the time you receive certain services. A typical example would be an office visit copay due when visiting your physician's office for treatment.

Allowed Amount—The maximum amount your health plan will pay for a specific service. In-network providers agree to accept the allowed amount as payment in full.

Coinsurance—A cost-sharing method that requires you pay a portion of the allowed amount for certain medical services.

Deductible—A set dollar amount you pay for covered services you receive before your insurer will make a payment.

Out-of-pocket maximum—The maximum amount of deductible and coinsurance payments that you will pay for health services each calendar year.

* Some definitions may vary slightly by plan. In case of a conflict between your legal plan documents and this information, the plan documents will govern.

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