

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/ \$5/\$20/\$40 RX

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®



excellusbcbs.com

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/
\$5/\$20/\$40 RX**

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
Office visit copay (Primary Care Physician)	Subject to deductible and coinsurance
Office visit copay (Specialist)	Subject to deductible and coinsurance
Coinsurance	20%
Deductible	\$100individual / \$300 family

Questions? For assistance call (877) 253-4797,
Call our TTYphone at 1 (800) 421-1220,
or visit us at excellusbcbcs.com/cnycoop

Type of Care/Plan Benefits	Coverage
Plan features <ul style="list-style-type: none"> • Primary Care Physician (PCP) • Referrals • Out of network benefits • Out of area benefits • Student/Dependent coverage • Domestic partner Plan cost-sharing highlights <ul style="list-style-type: none"> • Office visit copay (Primary Care Physician) • Office visit copay (Specialist) • Coinsurance • Deductible • Annual coinsurance maximum • Annual pharmacy maximum 	<ul style="list-style-type: none"> • No copay, office visit covered subject to deductible and coinsurance • Not required • Covered • Coverage provided worldwide through the BlueCard program. • Qualified dependents and students are covered to age 26. • Not covered <ul style="list-style-type: none"> • No copay, office visit covered subject to deductible and coinsurance • No copay, office visit covered subject to deductible and coinsurance • 20%, enhanced benefits only, unless noted • \$100 individual / \$300 family, enhanced benefits only • \$400 individual / \$1200 family, enhanced benefits only • \$2000 individual / \$6000 family

type of care/plan benefits	Coverage
Wellness Incentive <ul style="list-style-type: none"> • Stay healthy with great programs and incentives! Preventive Health Care Services <ul style="list-style-type: none"> • Well child visits • Adult routine physical exams • Adult immunizations • Mammography • Pap smear • Routine GYN exam • Prostate cancer screening • Routine vision • Colonoscopy Physician Office Services <ul style="list-style-type: none"> • Diagnostic office visits • Diagnostic x-rays • Diagnostic laboratory and pathology • Allergy tests • Allergy injections • Chemotherapy • Radiation therapy Maternity Services <ul style="list-style-type: none"> • Prenatal and postpartum care • Hospital care for mom (including delivery) • Newborn nursery care Prescription Drug	<ul style="list-style-type: none"> • Blue365 - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids. <ul style="list-style-type: none"> • Covered in full • Covered in full for 1 exam per year • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • Not covered • Covered in full <ul style="list-style-type: none"> • Subject to deductible and coinsurance • Covered in full • Covered in full • Subject to deductible and coinsurance • Subject to the deductible and coinsurance • Covered in full • Covered in full <ul style="list-style-type: none"> • Covered in full • Covered in full • Covered in full

Type of Care/Plan Benefits	Coverage
<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> \$5/\$20/\$40
Inpatient Hospital Benefits <ul style="list-style-type: none"> Hospital benefits Physician visits in the hospital Inpatient physical rehabilitation 	<ul style="list-style-type: none"> Covered in full for unlimited days Covered in full Covered in full for 30 days. After basic benefits exhausted, not subject to deductible and coinsurance for unlimited days Covered in full Covered in full
<ul style="list-style-type: none"> Surgery Anesthesia 	
Emergency Care <ul style="list-style-type: none"> Emergency room care Freestanding urgent care center Ambulance 	<ul style="list-style-type: none"> Covered in full Covered in full Covered in full
Outpatient Hospital Benefits <ul style="list-style-type: none"> Diagnostic x-rays Diagnostic laboratory and pathology Surgical care Chemotherapy Radiation therapy 	<ul style="list-style-type: none"> Covered in full Covered in full Covered in full Covered in full Covered in full
Mental Health and Chemical Dependence <ul style="list-style-type: none"> Inpatient mental health care Outpatient mental health care Inpatient chemical dependence Outpatient chemical dependence 	<ul style="list-style-type: none"> Covered in full for unlimited days Covered in full for unlimited visits Covered in full for unlimited days Covered in full for unlimited visits
Other Services <ul style="list-style-type: none"> Diabetic insulin and supplies Skilled nursing facility 	<ul style="list-style-type: none"> Covered in Full Covered in full for 100 days. After basic benefits exhausted, not subject to deductible and coinsurance for unlimited days 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 Covered in full for unlimited days Subject to deductible and coinsurance, limited to 100 visits per calendar year Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance Subject to deductible and coinsurance Not covered Not covered
<ul style="list-style-type: none"> Home care 	
<ul style="list-style-type: none"> Hospice Outpatient therapy 	
<ul style="list-style-type: none"> Durable medical equipment External prosthetics Chiropractic Acupuncture Dental 	



HEALTHY LIVING IS JUST A DEAL AWAY

Join Blue365 and start saving today!

Blue365 gives you access to savings across all aspects of your life— including 20 percent off on Fitbit devices and over \$800 off Lasik, discounts on healthy, organic meal delivery services like Sun Basket, and much more!

Register now for free to take advantage of Blue365. It's an online destination where participating members can find healthy deals and exclusive discounts, all you need is your Excellus BlueCross BlueShield member card to get started.

Get started today at

www.Blue365Deals.com/register

Exclusive savings from



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19-027-V05

TAKE YOUR COVERAGE WHEREVER LIFE TAKES YOU

With access to the largest provider network in the world, your Excellus BlueCross BlueShield plan offers a world of options. Our members have access to medical assistance services, doctors, and hospitals in all 50 states and more than 200 countries and territories around the world. Whether you live, work or travel across the country or across the globe, you can have confidence knowing that quality care can be accessed wherever and whenever you need it. And in most cases, you can take advantage of savings the local BCBS company has negotiated with its doctors and hospitals.

BlueCard® for Coverage in the United States

- ▶ Always carry your current member ID card.
- ▶ Visit ExcellusBCBS.com/FindaDoctor or download the **Excellus BCBS mobile app** to find a provider or medical facility near you. You'll be able to narrow your search by ZIP code, county, specialty, or even doctor's name. For personalized results based on your plan, sign into the tool as a member.
- ▶ If you're a PPO member, always use a BlueCard PPO doctor or hospital to ensure you receive the highest level of benefits.
- ▶ Call us for precertification or prior authorization, if necessary. Refer to the phone number on the back of your member card.
- ▶ When you arrive at the participating doctor's office or hospital, show the provider your member card so they can identify your benefit level.



After you receive care in the U.S., you should:

1

Not have to complete
any claim forms.

2

Not have to pay upfront for
medical services, except for
the out-of-pocket expenses
(non-covered services, deductible,
copayment and coinsurance)
you normally pay.

3

Receive an explanation of
benefits from Excellus BCBS.



Blue Cross Blue Shield Global® Core for International Coverage

- Always carry your current member ID card.
- Before you travel, contact Excellus BCBS for coverage details. Coverage outside the United States may be different.
- If you need medical assistance, call the Blue Cross Blue Shield Global Core Service Center (see number below) or use the Global Core mobile app to locate providers. An assistance coordinator, in conjunction with a medical professional, can arrange a physician appointment or hospitalization, if necessary. **If it's an emergency, go directly to the nearest hospital.**

Inpatient claims: Call the Blue Cross Blue Shield Global Core Service Center if you need inpatient care to arrange direct billing.

- In most cases, you should not need to pay upfront for inpatient care at Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core, call Excellus BCBS for precertification or preauthorization. Refer to the phone number on the back of your member card.

Professional claims: You may need to pay upfront for outpatient and doctor care, or inpatient care not arranged through the Service Center. Visit [BCBSGlobalCore.com/claims](https://www.bcbsglobalcore.com/claims) to file an eClaim or to download a blank international claim form.

Contact Blue Cross Blue Shield Global Core

If you have questions about Blue Cross Blue Shield Global Core or need medical care while abroad, call **+1.800.810.BLUE (2583)** or collect at **+1.804.673.1177**.

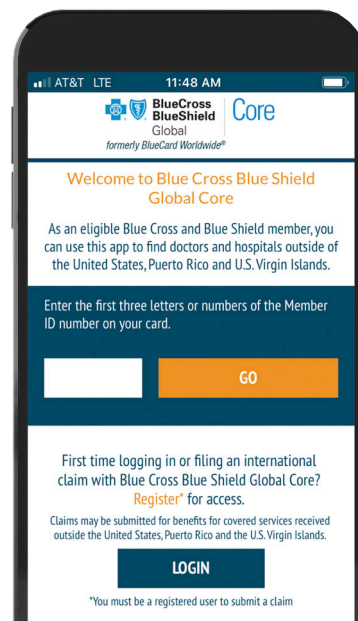
Download

The Excellus BCBS and Blue Cross Blue Shield Global Core mobile apps are available for Apple and Android devices. Visit the appropriate app store to download the latest apps for your device.



The Global Core app allows you to:

- Search providers for medical, dental, or mental health care **and map them using GPS technology.**
- Find a medication's **availability, generic name, and local brand name.**
- Access embassy information including location, contact, and GPS technology.
- Translate medical terms and phrases **for many symptoms and situations; use the audio feature to play the translation.**
- File International Claims conveniently and securely.



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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。

B-7410 / 14111-20



EVERYTHING YOU NEED IN A SINGLE ONLINE SEARCH





FIND DOCTORS. COMPARE COSTS. CONNECT WITH CONFIDENCE.

Our online search tool lets you estimate medical costs and find providers in your neighborhood and across the country. Now you can connect more quickly to care and better plan for medical expenses.





LOG IN FOR RESULTS
PERSONALIZED TO
YOUR PLAN, SPENDING,
AND DEDUCTIBLE.



FIND A DOCTOR WHO FITS ALL YOUR NEEDS

-  Search doctors, specialists, urgent care, hospitals, and more in our local and national networks
-  Filter results by specialty, languages spoken, if accepting new patients, and more
-  See a side-by-side comparison of providers and create a PDF of results to save, share, or print
-  Share your experiences by reading and leaving provider reviews

ESTIMATE COSTS TO HELP BUDGET FOR EXPENSES

-  Log in for estimated out-of-pocket medical costs based on your year-to-date spending and deductible
-  Research estimated medical costs across more than 1,600 treatment categories and 400+ procedures
-  Filter results by cost, treatments provided, location, and more
-  Access treatment timelines to understand the stages of care and costs

Get started at ExcellusBCBS.com/FindCare



Network coverage may vary based on your plan. Estimate Medical Costs tool may not be available to all plans.

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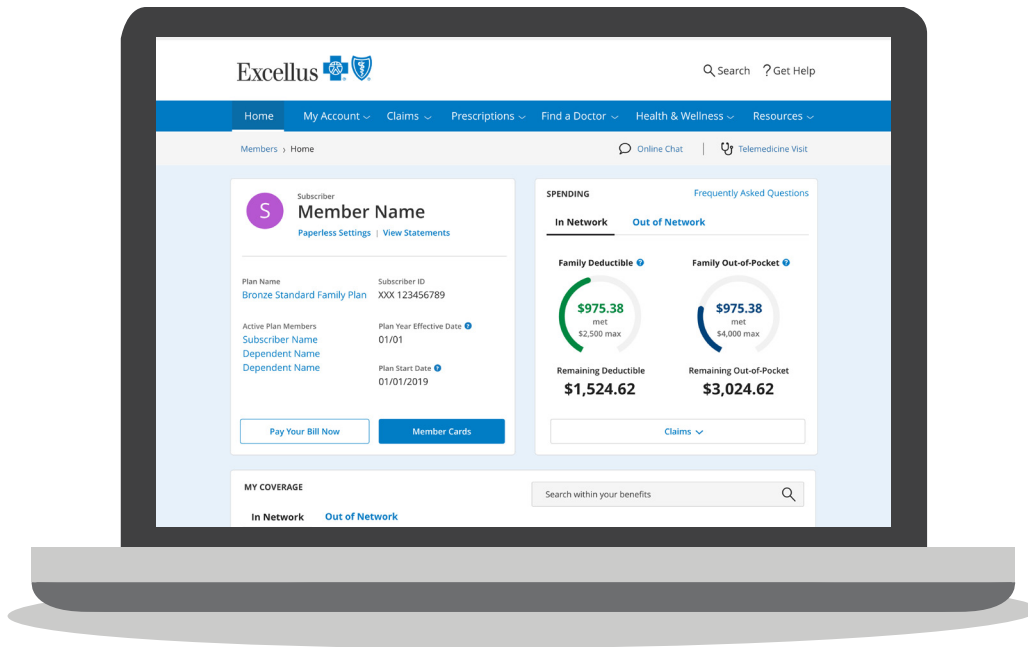
B-7246



IT'S YOUR PLAN. GET MORE OUT OF IT ONLINE.



Making the most of your plan shouldn't be complicated. When you sign up for an Excellus BlueCross BlueShield online member account, you get instant access to a variety of tools and other resources to make living healthy a little easier.

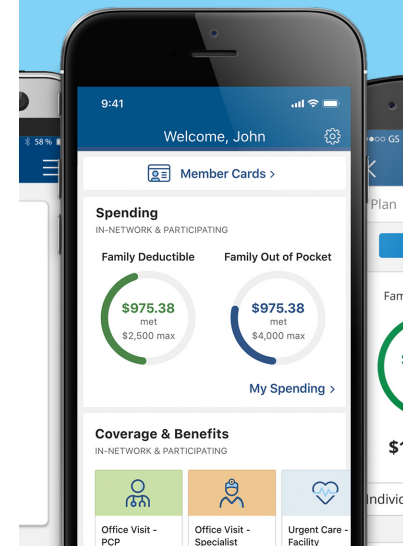


- 1 My Account**
Create an online account to access your member card, view a summary of benefits and coverage, claims, go paperless, and more.
- 2 Find a Doctor/Dentist**
Easily find access to care locally, nationally, and globally.
- 3 Spending**
Gives a breakdown of your health spending.
- 4 Coverage & Benefits**
Shows a summary of your plan details.
- 5 Claims**
Allows you to submit and view claims.
- 6 Get Rewards**
Provides quick access to spending and rewards programs.
- 7 Estimate Medical Costs**
Research and get a personalized estimate of out-of-pocket medical costs for over 1,600 treatments and over 400 procedures.

Visit Member.ExcellusBCBS.com to register today.

DOWNLOAD THE EXCELLUS BCBS APP.

Take your health plan with you for on-the-go access 24/7.



View your member card.

Track deductibles and out-of-pocket spending.

Find a provider or medical facility.

Access your benefits and claims information.



MORE BENEFITS, ACCESS, AND CONTROL IN 5 EASY STEPS

If you have a few minutes, you have plenty of time to create your online member account. Make sure you're getting the most value out of your health plan with a breakdown of how you're using your benefits, the ability to see and submit claims, go paperless, and more.

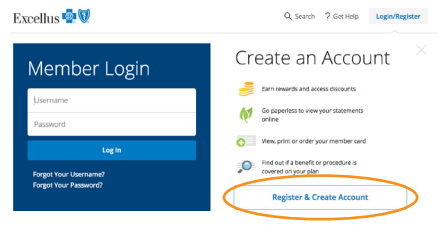
1 In Your Browser, Type Member.ExcellusBCBS.com

This will take you directly to the registration screen.

Q | Enter Address

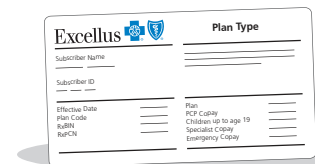
2 Create a New Account

Select the Register & Create Account button on the right side of the screen.



3 Complete the Form

You'll need your Subscriber ID, so be sure you have your Member Card handy.



4 Choose a Username and Password

You'll also choose a pair of security questions in case you forget either of these.

Username*
Password*

5 Verify Your Email Address

We'll send you an email to verify your new account. Sign in and you're ready to go!



**DON'T FORGET
TO DOWNLOAD
THE APP**

Log in to more features, tools, and resources online.



View a Summary
of Benefits and
Coverage



Find a Doctor
or Dentist



Track Deductible
and Out-of-Pocket
Spending



Submit and
View Claims



Estimate
Medical Costs



View Online
Member Cards



Download
Statements
and Forms

**Create your account at Member.ExcellusBCBS.com today
for anytime, anywhere access to your health plan.**

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B-7184



Prescription home delivery

Signing up is as easy as 1, 2, 3...



Consider home delivery if you:



Want some of
your life back?
Get a 90-day
supply all at once.



Take the same
medication(s)
every month.



Need help
managing
your family's
prescriptions.

Home delivery of prescriptions is safe and confidential:



Insulated packaging
protects your
medications from the
sun, rain and cold.



Discreet packaging
does not reveal
contents.

Delivery straight
to your mailbox.







Automatic refill option. Free standard shipping.
Express delivery available. Pharmacists available
to answer questions. **Call today!**





KNOW WHERE TO GET CARE

You have options when choosing where to go for medical care. Here are some tips to help you make the right choice for where to go the next time you need care.

WHERE TO GO	COST	CHOOSING THE BEST OPTION
 <p>Primary Care Physician</p>	\$	<p>Your doctor should be your first choice for routine medical care or minor illnesses or injuries that are not an emergency. You may have an office visit copay depending on your plan.</p> <p>TIP: If you can't make it to their office, you might be able to schedule a remote visit with your doctor through phone or video connection, known as telehealth. Check with your primary care physician to see if they offer this option.</p>
 <p>Telemedicine</p>	\$	<p>If your doctor isn't available for minor medical or behavioral health needs, telemedicine may be an option for you. Telemedicine gives you fast and convenient access to a doctor 24/7/365 wherever you are through your phone, tablet, or computer. Register today at Member.ExcellusBCBS.com</p> <p>Medical Telemedicine for:</p> <ul style="list-style-type: none"> • Allergies • Asthma • Cold & Flu • Constipation • Diarrhea • Fever • Joint Aches • Nausea • Pink Eye • Rashes • And more <p>Behavioral Health Telemedicine for:</p> <ul style="list-style-type: none"> • Addictions • Anxiety • Bipolar disorders • Depression • Eating disorders • Grief and loss • LGBTQ support • Panic disorders • Stress • And more
 <p>Urgent Care</p>	\$\$	<p>If your medical issue is not life threatening and your doctor isn't available, you can visit an urgent care center and get the care you need.</p> <ul style="list-style-type: none"> • Minor cuts, bruises or burns • Muscle strains or sprains • Cold and flu treatment
 <p>Emergency Room</p>	\$\$\$	<p>You should only go to the emergency room if you have a serious or potentially life-threatening medical condition. Call 911 for assistance. Do not try to drive yourself there.</p>

PEACE OF MIND. FREE OF CHARGE.

SCHEDULE YOUR ANNUAL CHECKUP TODAY



Stay a step ahead of future health issues by staying on top of your routine checkups today.

✓ PREVENTIVE CARE KEEPS YOU HEALTHY. AND IT'S COVERED.*



Annual Routine Checkup



Diabetes (Type 2) Screening



Annual OB/GYN Visit



Immunizations



Cholesterol Screening



Mammography Screening



Colorectal Cancer Screening



Well-Child Visit

See the full list of preventive care services available to you
at ExcellusBCBS.com/PreventiveCare

Download the Excellus BCBS app and register your online account.



*A well visit or preventive service can sometimes turn into a "sick visit," in which out-of-pocket expenses for deductible, copay and/or coinsurance may apply. There may also be other services performed in conjunction with the above preventive care services that might be subject to deductible, copay and/or coinsurance. Does not include procedures, injections, diagnostic services, laboratory and X-ray services, or any other services not billed as preventive services.

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THE DOCTOR WILL SEE YOU NOW. WHEREVER. WHENEVER.

When you're feeling achy, stuffy, and feverish, the last thing you want to do is drive to your doctor and sit in a waiting room. Telemedicine gives you fast access to medical and behavioral health care 24/7/365, from the comfort of your home, desk, or hotel room. **All you need to do is activate it through your online member account and download the MDLIVE app.**

Rest assured, our health care professionals deliver the same quality of care you receive from your own doctor, but more conveniently via your phone, tablet, or computer. There's even a chance you'll see your own doctor on the MDLIVE roster.

When do you use telemedicine?

- Instead of going to urgent care or the emergency room for minor and non-life-threatening conditions
- Whenever your primary care doctor is not available
- If you live in a rural area and don't have access to nearby care
- When you're traveling for work or on vacation

Here are some of the common medical conditions treated with telemedicine:

Adults

- Allergies
- Cold and Flu
- Ear Infections
- Fever
- Headache
- Joint Aches and Pains
- Nausea and Vomiting
- Pink Eye
- Rashes
- Sinus Infections
- Sunburn
- Urinary Tract Infections*

Children

- Cold and Flu
- Constipation
- Earache*
- Fever*
- Nausea and Vomiting
- Pink Eye

*MDLIVE does not provide support for urinary tract infections in males; does not provide support for earache conditions for children under 12 years old; does not provide support for fever-related conditions for children under 3 years old.

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Telemedicine is good for the mind as well as the body.

In addition to whenever, wherever access to medical doctors, you can also video conference with a psychiatrist or choose from a variety of licensed therapists from the privacy of your own home. You can even schedule recurring appointments to establish an ongoing relationship with one therapist.

If you think behavioral health counseling might be right for you, take one of our free online assessments at **MDLIVE.com/BH-Assessments**. Here are some conditions people rely on behavioral health telemedicine for:

- Addiction
- Eating Disorders
- Panic Disorders
- Bipolar Disorders
- Grief and Loss
- Stress
- Depression
- LGBTQ Support
- Trauma and PTSD

Telemedicine is covered just like a trip to the doctor.

If your doctor's office visit is...	Then your medical and behavioral health telemedicine program benefit cost share is...
Covered with a copay	\$10 (or equal to the PCP copay if PCP copay is less than \$10)
Covered with copay/deductible	\$10 copay subject to deductible (or equal to the PCP copay if PCP copay is less than \$10)
Covered deductible/covered in full	Deductible/covered in full
Covered with deductible/coinsurance	Deductible/coinsurance
Covered with coinsurance only	Coinsurance only

Don't wait until you need it. There are four easy ways to activate telemedicine today.

WEB - Register/Log in at ExcellusBCBS.com/Member

APP - Download the MDLIVE app

TEXT - Text EXCELLUS to 635483

VOICE - Call 1-866-692-5045

DID YOU KNOW?



of doctor's office visits could be handled over the phone.¹



days is the average wait time between scheduling an appointment and seeing a primary care doctor.²



of emergency room visits can potentially be prevented with telemedicine.³

¹ "New medical cost savings program: Telemedicine means great discounts." R. Schultz, January 9, 2010.

² Based on MDLIVE data, 2016.

³ Based on New York State Department of Health data, 2016.

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MDLIVE does not replace the primary care physician. MDLIVE is not an insurance product. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services. MDLIVE phone consultations are available 24/7/365, while video consultations are available during the hours of 7 am to 9 pm ET 7 days a week or by scheduled availability. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use visit www.mdlive.com/terms-of-use. MDLIVE is an independent company, offering telehealth services in the Excellus BlueCross BlueShield service area. Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, origin, age, disability, or sex.

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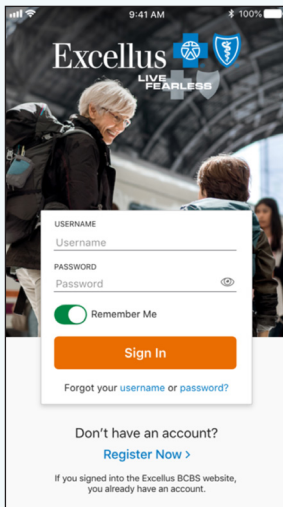
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GET READY FOR A MORE CONVENIENT HEALTH CARE EXPERIENCE

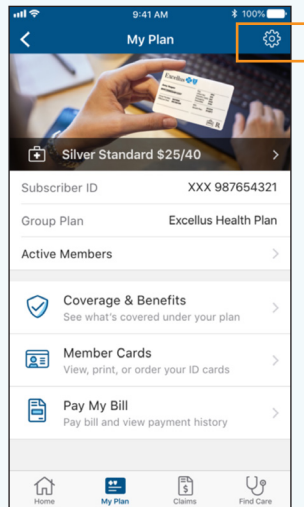
YOUR WELLFRAME® QUICK START GUIDE

Free to all Excellus BlueCross BlueShield members, the Wellframe® App gives you instant access to a dedicated care manager, dietitians, nurses, and other health care professionals to help you meet your health and wellness goals.

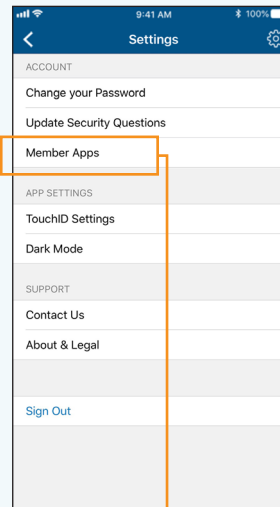
To get started, follow these simple steps:



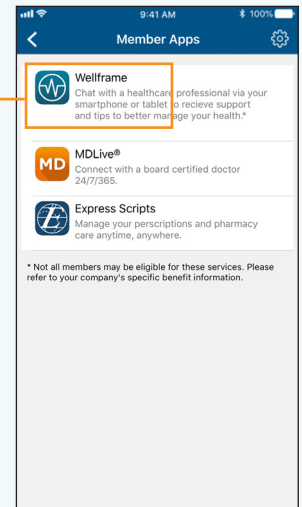
- 1 Download the **Excellus BCBS app** and register your online account.



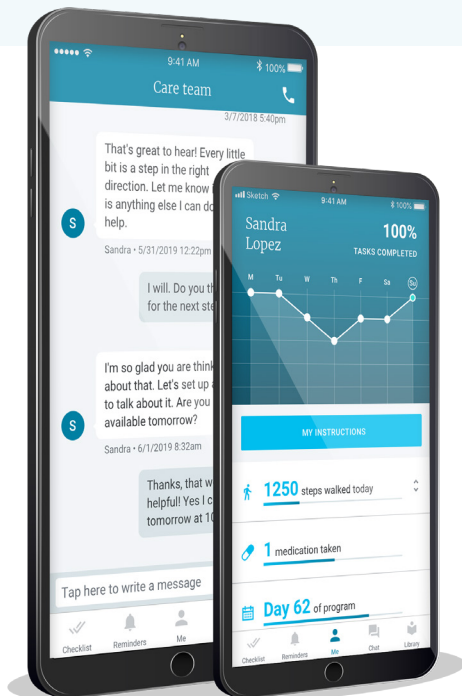
- 2 Open your **Excellus BCBS app** and click the settings icon on the top right.



- 3 Click **Member Apps** from the dropdown menu.



- 4 Click **Wellframe®** and enter code **"EXCELLUS"** to download.



Health care experts and support at your fingertips

Once you download Wellframe®, you're ready to:

- Connect with a dedicated care manager
- Create a personalized health plan and track progress
- Text with health care professionals at any time
- Receive daily tips, reminders, and videos
- Join programs within the app for additional support



Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, origin, age, disability, or sex. 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。

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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				
<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> At my request</div><div><input type="checkbox"/> Other: _____</div></div>				
PART D: HEALTH PLAN CAN SHARE THE FOLLOWING INFORMATION <i>(select D-1 <u>or</u> D-2 and if applicable, D-3)</i> NOTE: Skip this section if psychotherapy was checked at the top of this form				
<p>D-1. <input type="checkbox"/> 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.</p> <p style="text-align: center;">- OR -</p> <p>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.</p> <div style="display: flex; flex-wrap: wrap;"><div style="width: 50%;"><input type="checkbox"/> Enrollment (e.g. eligibility, address, dependents, birth date)</div><div style="width: 50%;"><input type="checkbox"/> Benefit (e.g. benefit coverage, usage, limits)</div><div style="width: 50%;"><input type="checkbox"/> Claim (e.g. status, provider, dates, payment, diagnosis)</div><div style="width: 50%;"><input type="checkbox"/> Clinical records (e.g. doctor/facility, case management)</div><div style="width: 50%;"><input type="checkbox"/> Other limitation: _____</div><div style="width: 50%;"><input type="checkbox"/> Date Range _____ to _____</div></div> <p style="text-align: center;">- AND, IF APPLICABLE -</p> <p>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.</p> <div style="display: flex; flex-wrap: wrap;"><div style="width: 33%;"><input type="checkbox"/> Genetic testing</div><div style="width: 33%;"><input type="checkbox"/> Substance use disorder</div><div style="width: 33%;"><input type="checkbox"/> Mental health (excluding psychotherapy notes)</div><div style="width: 33%;"><input type="checkbox"/> Sexually transmitted diseases</div><div style="width: 33%;"><input type="checkbox"/> Abortion</div></div> <p>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</p>				
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.

B-5495

Commercial Group Health Insurance Application/Change Form

CONFIDENTIAL

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

Cortland City Schools

COOPERATIVE HEALTH INSURANCE FUND

Employer Name

Association/Chamber Name (if applicable)

Group Administrator's Signature (required)

Date

Employee Number

Department Number

Medical Information

00063225

Medical Group Number (8 digits)

Medical Subgroup Number (4 digits)

Medical Class Number (4 digits)

If enrolling in a Medical plan, who do you need coverage for?

- ☐ Self Only
☐ Self & Child(ren)
☐ Self & Spouse, or
Self & Domestic Partner
☐ Family

_____/_____/_____
Medical Effective Date

Subscriber Status:

- ☐ Actively Working
☐ Retired
☐ Disability
☐ Canceled
☐ COBRA

Dental Information

00059478

Dental Group Number

Dental Subgroup Number

Dental Class or Package #

If enrolling in a Dental plan, who do you need coverage for?

- ☐ Self Only
☐ Self & Child(ren)
☐ Self & Spouse, or
Self & Domestic Partner
☐ Family

_____/_____/_____
Dental Effective Date

Medical Plan Selection

- | | |
|---|---|
| <input type="checkbox"/> (CSS) Classic Blue | <input type="checkbox"/> (BXV) Classic Blue |
| <input type="checkbox"/> (CKT) Classic Blue | <input type="checkbox"/> (BXX) Classic Blue |
| <input type="checkbox"/> (BXW) Classic Blue | <input type="checkbox"/> (CCZ) Classic Blue |
| <input type="checkbox"/> | <input type="checkbox"/> |

Dental Plan Selection

- ☐ (DE) Dental

Section 2: Subscriber's Information

Last Name

First Name

Middle Initial Title (e.g., Jr, Sr, III, etc.)

Street Address

City

State

Zip Code

Phone

Birthdate: ____/____/____

Gender:

- ☐ Male
☐ Female

Social Security Number** _____

Date of Hire/Rehire: ____/____/____

Retire Date: ____/____/____

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

Subscriber's Medicare Number (if applicable) ☐ Age 65+ ☐ Disability
☐ End Stage Renal *

_____/_____/_____
Part A Effective Date

_____/_____/_____
Part B Effective Date

Section 3: Reason for enrollment or change - To be completed by the Group Administrator - Not required for cancellations**Enrollment Opportunity:** ☐ New Hire ☐ Rehire ☐ Open Enrollment ☐ Medicare eligible**Special Enrollment Opportunity:** ☐ Newly Eligible Dependent: ☐ Newborn ☐ Marriage ☐ Other _____
☐ Change in employment status ☐ A move in or out of the service area
☐ Involuntary loss of coverage ☐ Former dependent regains eligibility**Date of Event** ____ / ____ / ____**COBRA Election - Please indicate the reason for COBRA if applicable:**☐ Left Employment/Retired ☐ Divorce/Legal Separation ☐ Loss of Student Status ☐ Death of Spouse
☐ Disability ☐ Dependent Reached Max Age ☐ Other: _____**Demographic Change:** ☐ Address ☐ Birthdate ☐ Subscriber Name ☐ Dependent Name ☐ Phone Number**Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?****Subscriber****Cancel Code:****Medical Cancel Date:****Dental Cancel Date:****Cancel Codes:**

SB02-Left Employment SB05-Per Group Request SB06-Subscriber Request (voluntary) SB07-Deceased SB09-Enrolled in Error

Dependent(s)**Dependent Name:****Cancel Code:****Medical Cancel Date:****Dental Cancel Date:****Cancel Codes:**M001-Per Group Request M004-Enrolled in Error M008-Moved Out of Area M013-Ineligible
M002-Deceased M005-Divorced M010-Overage Dependent M014-YAO Ineligible
M003-Per Subscriber Request M007-Per Member Request (voluntary) M011-No Longer a Student M040-Mx Same Group**Section 5: Information about who you would like coverage for (dependent information)**☐ Spouse ☐ Domestic Partner ☐ Dependent Child ☐ Disabled Dependent Child (Separate application form required)
☐ Other _____**Last Name** (if different) _____ **Title** _____ **First Name** _____ **MI** _____ **Social Security Number** ** _____**Gender:**☐ Male ☐ Female **Birthdate** ____ / ____ / ____Is dependent a full time student over age 19? ☐ Yes ☐ NoIf yes, please provide name of college/university _____ **Expected Graduation Date:** ____ / ____ / ____**Medicare Eligible** ☐ Yes ☐ No If yes, indicate reason ☐ Age 65+ ☐ Disability ☐ End Stage Renal *
Part A Effective Date: ____ / ____ / ____ Part B Effective Date: ____ / ____ / ____

Medicare Number (if applicable) _____

↓ Additional Dependent(s) ↓☐ Dependent Child ☐ Disabled Dependent Child (Separate application form required) ☐ Other _____**Last Name** (if different) _____ **Title** _____ **First Name** _____ **MI** _____ **Social Security Number** ** _____**Gender:**☐ Male ☐ Female **Birthdate** ____ / ____ / ____Is dependent a full time student over age 19? ☐ Yes ☐ NoIf yes, please provide name of college/university _____ **Expected Graduation Date:** ____ / ____ / ____**Medicare Eligible** ☐ Yes ☐ No If yes, indicate reason ☐ Age 65+ ☐ Disability ☐ End Stage Renal *
Part A Effective Date: ____ / ____ / ____ Part B Effective Date: ____ / ____ / ____

Medicare Number (if applicable) _____

☐ Dependent Child ☐ Disabled Dependent Child (Separate application form required) ☐ Other _____

Last Name (if different) _____ Title _____ First Name _____ MI _____ Social Security Number ** _____

Gender: ☐ Male ☐ Female Birthdate ____ / ____ / ____

Is dependent a full time student over age 19? ☐ Yes ☐ No Expected Graduation Date: ____ / ____ / ____

If yes, please provide name of college/university _____

Medicare Eligible ☐ Yes ☐ No If yes, indicate reason ☐ Age 65+ ☐ Disability ☐ End Stage Renal *

Part A Effective Date: ____ / ____ / ____ Part B Effective Date: ____ / ____ / ____

Medicare Number (if applicable) _____

Note: Use an additional application if more than three dependents need coverage.

Section 6: Other coverage information (Required) - You may be contacted for additional information

Have you or any member of your family been enrolled in other medical or dental coverage? ☐ Yes ☐ No

If yes, what type of coverage? ☐ Medical ☐ Dental

What is the effective date of the other coverage? ☐ Medical: ____ / ____ / ____ ☐ Dental: ____ / ____ / ____

What is the name of the other carrier? _____

Are you keeping the coverage? ☐ Yes ☐ No

If no, when will the coverage end? ____ / ____ / ____

Policyholder's name _____ ID# _____

Who did the insurance cover? ☐ Self Only ☐ Self & Spouse/Domestic Partner ☐ Self & Child(ren) ☐ Family

Section 7: Release - You must sign and date this form to be eligible for health insurance

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

PREFERRED PROVIDER ORGANIZATION (PPO)

I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.

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.

Subscriber Signature _____ Date _____

Please return to P.O. Box 21146 Eagan, MN 55121
If you have questions, please contact your Group Administrator. Or, visit us at: ExcellusBCBS.com

Instructions for completing the Group Health Insurance Application

Section 1: Employer Group & Benefit Information

This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical and/or dental group numbers and information must be populated. Select who you need coverage for on the medical and/or dental plan(s) and indicate the subscriber's status. Next, select the medical and/or dental plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

Section 2: Subscriber's Information

This section should be completed by the Subscriber.

****We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.**

*** There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.**

Section 3: Reason for enrollment or change

Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. 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 for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

Section 5: Information about who you would like coverage for (dependent information)

Please include information about all the people who you would like coverage for.

Use an additional application if more than three dependents need coverage.

If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.

Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum dependent age. Please contact your Group Administrator for the appropriate form.

****We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.**

*** There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.**

Section 6: Other coverage information (Required)

Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 7: Release

Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.

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.

