BENEFITS

Genesee Area Healthcare Plan

PPO D-2 Benefit Booklet 2025-2026

Excellus

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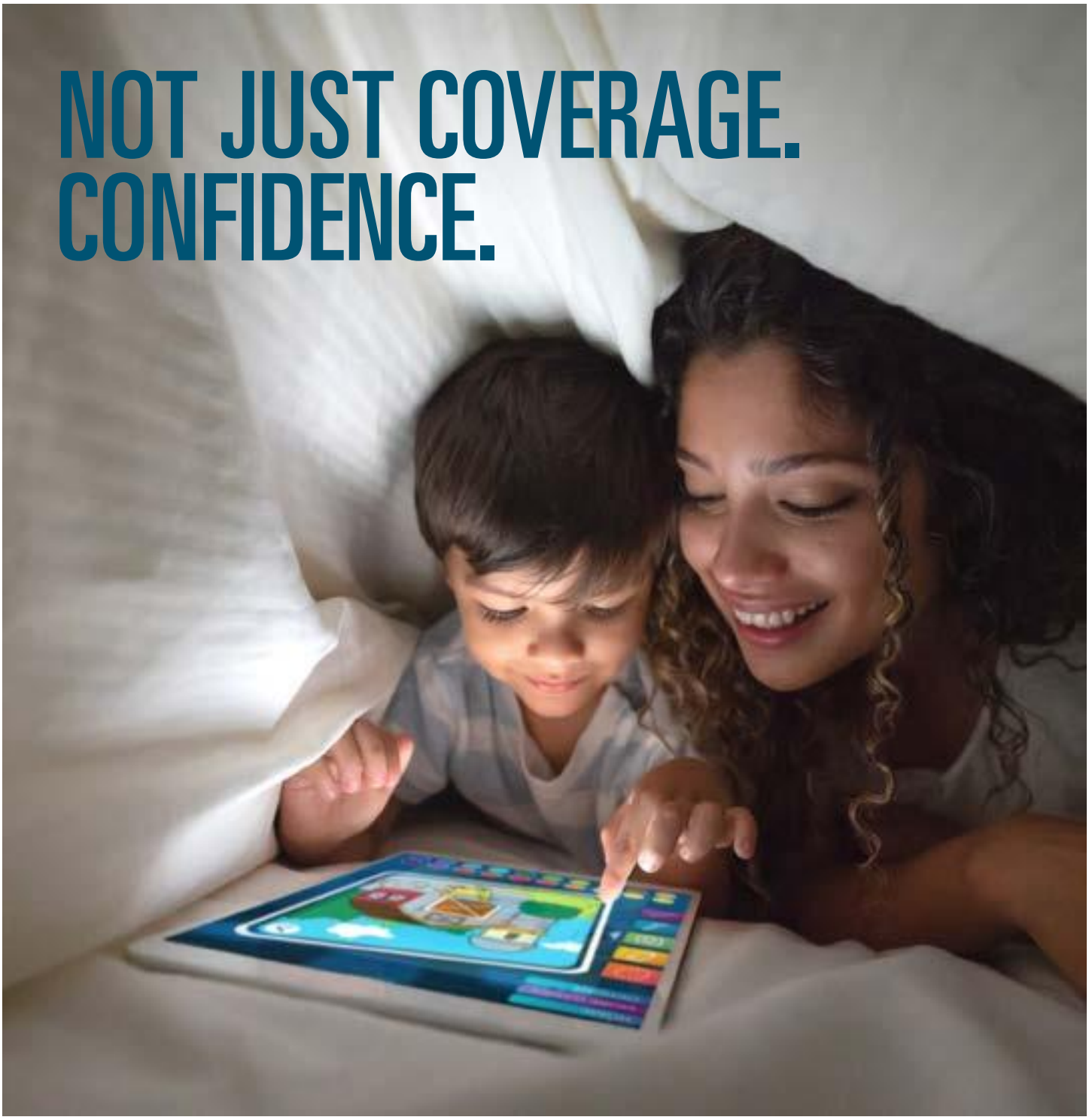

Excellus

PLAN DESCRIPTION

PLAN ADMINISTRATOR:	GENESEE AREA HEALTHCARE PLAN (GAHP) c/o Genesee Valley BOCES 27 Lackawanna Ave Mount Morris, NY 14510
TYPE OF PLAN:	• Medical • Prescription Drug • Dental
AGENT FOR SERVICE OF LEGAL PROCESS:	GENESEE AREA HEALTHCARE PLAN (GAHP)
PLAN NUMBER:	501
PLAN YEAR:	July 1 through June 30 ****PLEASE SEE PAGE 7 FOR 1/1/26 BENEFIT CHANGES****
PLAN REVISION DATE:	July 1, 2025
FUNDING AND ADMINISTRATION:	The Plan is funded by direct benefit payments by the Participating Schools for claims having been paid on behalf of the Participating Schools by Excellus BlueCross BlueShield.
HOW TO CONTACT US:	Excellus BlueCross BlueShield 165 Court Street Rochester, NY 14647 585-325-3630 Toll-Free 877-253-4797
BENEFIT AND CLAIMS:	Customer Service 585-325-3630 or 1-877-253-4797 Monday - Thursday 8AM - 7PM Friday 9AM - 7PM Saturday 9AM - 1PM E-Mail: CustomerService@excellus.com *E-mail our Customer Service Department with any inquiries*
HOW TO FIND A PPO PROVIDER:	Visit **www.excellusbcbs.com** or call 1-800-810-BLUE (2583) or Download the Excellus BCBS app on your smartphone via the Apple App Store or the Google Play Store

Preferred Provider Organization (PPO)

Who is a Preferred In-Network Provider:

1-800-810-BLUE (2583) www.excellusbcbs.com

A group of hospitals, physicians and ancillary providers that contract on a fee-for-service basis to provide comprehensive medical service. You can choose any provider as needed. Levels of coverage are higher and your out-of-pocket expenses are lower if you use participating network providers.

Benefit Summary for Genesee Area Healthcare PPO D-2 Plan

PLEASE SEE PAGE 7 FOR 1/1/26 BENEFIT CHANGES

Services	In-Network	Out-of-Network
HOSPITAL INPATIENT SERVICES		
Hospital Services	Covered at 80% subject to deductible for unlimited days of semi-private room for all medically necessary services for acute care.	Covered at 60% subject to deductible for unlimited days of semi-private room for all medically necessary services for acute care.
Skilled Nursing Facility Prior Authorization is required (refer to page 6).	Covered at 80% subject to deductible for up to 120 days per calendar year of semi-private room for all medically necessary services.	Covered at 60% subject to deductible for up to 120 days per calendar year of semi-private room for all medically necessary services.
Hospice	Covered at 80% for unlimited days.	Covered at 60%, subject to deductible, for unlimited days.
Inpatient Physical Rehabilitation Prior Authorization is required (refer to page 6).	Covered in full for up to 60 days per member per calendar year.	Covered at 60%, subject to deductible, for up to 60 days per member per calendar year.
	60 days is combined for In-and Out-of-Network.	
HOSPITAL OUTPATIENT SERVICES		
Diagnostic X-Ray – includes MRI, MRA, PET, and CAT scans. Prior Authorization is required (refer to page 6).	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Diagnostic Laboratory and Pathology	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Chemotherapy	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Radiation Therapy	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Surgical Care	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Pre-Admission Testing	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Routine Colonoscopy	Covered in full.	Covered at 60%, subject to deductible.
Diagnostic Colonoscopy	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.

Services	In-Network	Out-of-Network
EMERGENCY SERVICES		
Emergency Room Care	$250 copay per visit unless admitted to the hospital within 24 hours.	$250 copay per visit unless admitted to the hospital within 24 hours.**
Freestanding Urgent Care Center	$35 copay per visit.	Covered at 60%, subject to deductible.
Air Ambulance	Covered at 80%, subject to deductible.	Covered at 80%, subject to deductible.**
Ambulance	$75 copay.	$75 copay.**
PHYSICIAN SERVICES		
Hospital Inpatient		
Physician Visits	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.**
Surgery	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Anesthesia	Covered at 80%, subject to deductible.	Covered at 80%, subject to deductible.**
Physician's Office		
Diagnostic Office Visits	$30 PCP/$35 Specialist copay per visit.	Covered at 60%, subject to deductible.
Telemedicine (MDLive)	$10 copay per visit (MDLive).	No benefit available.
***Adult Routine Physicals**	Covered in full, once per calendar year.	Covered at 60%, subject to deductible, once per calendar year.
***Adult Immunizations**	$30 PCP/$35 Specialist copay per visit. Routine covered in full.	Covered at 60%, subject to deductible.
***Prostate Cancer Screening**	Covered in full.	Covered at 60%, subject to deductible.
***Mammography**	Covered in full.	Covered at 60%, subject to deductible.
***Routine Cervical Cancer Screening (Pap Smear)**	Covered in full, once per calendar year.	Covered at 60%, subject to deductible, once per calendar year.
***Routine OB/GYN Exam**	Covered in full, once per calendar year.	Covered at 60%, subject to deductible, once per calendar year.
***Well Child Visits**	**Same Benefit In- and Out-of-Network:** Periodic well child visits, immunizations, laboratory and other services ordered at the time of the visit covered in full, according to the American Academy of Pediatrics recommended schedule.	
***Allergy Injections**	Covered in full.	Covered at 60%, subject to deductible.

***Subject to Federal Guidelines**

**Accumulates towards the in-network annual out-of-pocket maximum.

Services	In-Network	Out-of-Network
Allergy Tests	$30 PCP/$35 Specialist copay per visit.	Covered at 60%, subject to deductible.
Chemotherapy	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Radiation Therapy	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Diagnostic Laboratory and Pathology	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.**
Diagnostic X-Ray – Includes MRI, MRA, PET, and CAT scans. Prior Authorization is required (refer to page 6).	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
MATERNITY SERVICES		
Hospital Charges for Mother (including delivery)	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible
Physician Charges for Mother	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Newborn Nursery Care	Covered at 80% coinsurance.	Covered at 60%, subject to deductible.
Prenatal/Postnatal Office Visits	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Fertility Treatment See details on page 16.	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES		
Inpatient		
Mental Health Care	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Chemical Dependency	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Outpatient		
Mental Health Care	$30 copay per visit.	Covered at 60%, subject to deductible.
Chemical Dependency	$30 copay per visit.	Covered at 60%, subject to deductible.
OTHER SERVICES		
Physical Therapy	Covered at 80%, subject to deductible, for up to 45 visits per member per calendar year.*	Covered at 60%, subject to deductible, for up to 45 visits per member per calendar year.*
Speech Therapy	Covered at 80%, subject to deductible, for up to 45 visits per member per calendar year.*	Covered at 60%, subject to deductible, for up to 45 visits per member per calendar year.*
Occupational Therapy	Covered at 80%, subject to deductible, for up to 45 visits per member per calendar year.*	Covered at 60%, subject to deductible, for up to 45 visits per member per calendar year.*

***45 visits is a combined maximum for Physical, Speech and Occupational Therapy.**

**Accumulates towards the in-network annual out-of-pocket maximum.

Services	In-Network	Out-of-Network
Home Care Prior Authorization is required (refer to page 6).	Covered at 80%, subject to a separate $50 deductible, for unlimited days per calendar year.	Covered at 75%, subject to a separate $50 deductible, for unlimited days per calendar year.
Durable Medical Equipment (DME) Prior Authorization is required (refer to page 6).	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Internal Prosthetics	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
External Prosthetics and Orthopedic Braces and Supports	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Foot Orthotics	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
Chiropractic Services	$35 copay per visit.	Covered at 60%, subject to deductible.
Acupuncture	$50 copay per visit. Up to 10 visits per calendar year.	Covered at 50%, subject to deductible. Up to 10 visits per calendar year.
Dental	$35 copay for an office visit when related to an accidental injury to sound, natural teeth and services are rendered within 365 days of the accident. Covered at 80%, subject to deductible, for surgery and x-rays.	Covered at 60%, subject to deductible, when related to an accidental injury to sound, natural teeth and services are rendered within 365 days of the accident.
Diabetic Insulin	Covered in full for 30-day supply for Retail. Covered in full for 90-day supply for Mail order.	Covered at 60%, subject to deductible.**
Diabetic Supplies	$20 copay per 30-day supply for Retail. $40 copay per 90-day supply for Mail order.	Covered at 60%, subject to deductible.**
Diabetic Equipment	$20 copay per 30-day supply for Retail. $40 copay per 90-day supply for Mail order.	Covered at 60%, subject to deductible.
Eye Exams	Diagnostic, related to disease or injury, $35 copay per visit. ***No coverage for routine eye exams or refractions.***	Diagnostic, related to disease or injury, covered at 60%, subject to deductible. ***No coverage for routine eye exams or refractions.***
Hearing	Routine evaluation $35 copay per member per calendar year. Diagnostic evaluation $35 copay per visit. ***Hearing aids not covered.***	Diagnostic evaluation covered at 60%, subject to deductible. ***Routine evaluation and Hearing aids not covered.***

**Accumulates towards the in-network annual out-of-pocket maximum.

Services	In-Network	Out-of-Network
Prescription Drugs	**Retail** Tier 1 $5 per 30-day supply Tier 2 $45 per 30-day supply Tier 3 $90 per 30-day supply **Mail Order** Tier 1 $10 per 90-day supply Tier 2 $90 per 90-day supply Tier 3 $180 per 90-day supply	No benefit available.
Out-of-Area Coverage	Coverage provided worldwide. See **international claims** details on page 14.	Coverage provided worldwide. See **international claims** details on page 14.
Dependent Coverage	Dependents to age 26.	Dependents to age 26.
Deductible (Calendar Year) ♦	$750 per member, $1,500 per 2-person and $2,250 per family.	$750 per member, $1,500 per 2-person and $2,250 per family.
Coinsurance	20% coinsurance, unless otherwise noted.	40% coinsurance, unless otherwise noted.
Annual Out-of-Pocket Maximum (Calendar Year) ♦	$2,250 per member, $4,500 per 2-person and $6,750 per family. All cost shares will accumulate to the Out-of-pocket maximum, to include deductibles, coinsurance, office visit copayments and prescription copayments.	$2,475 per member, $4,950 per 2-person and $7,425 per family. All cost shares will accumulate to the Out-of-pocket maximum, to include deductibles, coinsurance, office visit copayments and prescription copayments.
Lifetime Benefit Maximum	None.	None.
Plan Year	July 1 - June 30	July 1 - June 30

These services require Prior Authorization and are subject to medical necessity:

- All inpatient admissions, at least 1 week prior to admission (except Maternity & Emergency admissions)
- Skilled Nursing Facility admissions
- Home Health Care
- Home Infusion Therapy
- Organ and Tissue Transplants
- Durable Medical Equipment (DME), Prosthetics, and Orthotics over $200
- MRA, MRI, CAT scans and PET scans

This is not a contract. It is intended to highlight the coverage of this program.
Benefits are determined by the terms of the contract.
All benefits are subject to medical necessity unless otherwise specified.

♦ See page 12 for more information about the Annual Out-of-Pocket Maximum.

Benefit Changes Effective 1/1/26

Services	In-Network	Out-of-Network
EMERGENCY SERVICES		
Freestanding Urgent Care	$40 copay per visit.	No Change
PHYSICIAN SERVICES		
Physician's Office		
Diagnostic Office Visits	$30 PCP*/$40 Specialist copay per visit.	No Change
Adult Immunizations	$30 PCP*/$40 Specialist copay per visit. Routine covered in full.	No Change
Allergy Tests	$30 PCP*/$40 Specialist copay per visit. *No change to PCP copay from prior plan year	No Change
OTHER SERVICES		
Chiropractic Services	$40 copay per visit.	No Change
Dental	$40 copay for an office visit when related to an accidental injury to sound, natural teeth and services are rendered within 365 days of the accident. Covered at 80%, subject to deductible, for surgery and x-rays.	No Change
Eye Exams	Diagnostic, related to disease or injury, $40 copay per visit. No coverage for routine eye exams or refractions.	No Change
Hearing	Routine evaluation $40 copay per member per calendar year. Diagnostic evaluation $40 copay per visit. ***Hearing aids not covered.***	No Change

GENERAL PROVISIONS OF YOUR CONTRACT

Group Contract year: July 1 - June 30

Open Enrollment Period

Open enrollment is held annually during the month of June for an effective date of July 1.

Other than qualifying events (new hire, marriage, birth, etc.) all changes to your policy must be made during this time period.

Participants are required to **remain in a rider for a minimum of one year**, as long as they continue with the Genesee Area Healthcare Plan.

Identification Card

As the subscriber, you will receive two member ID cards which lists your name and subscriber identification number. Each dependent will receive their own member ID card mailed in its own envelope, regardless of their age (including newborns). The dependent's ID card will include the subscriber's name and the subscriber's identification number.

Carry your card at all times. Present it to hospitals, physicians and other healthcare providers when you receive care.

If you lose your card, contact Excellus BCBS Customer Service at 1-877-253-4797 to request a replacement.

ELIGIBILITY

Eligible subscribers must be US citizens, permanent residents, or non-immigrants whose authorization status permits employment.

New Hires/Rehires

You are eligible to enroll in the group health plan of a participating school district if:

1. You are an eligible employee; AND
2. You are performing the essential job duties according to your job description pursuant to the collective bargaining agreement or other contractual obligations of your position; AND
3. You are receiving your contractual salary if a salaried employee or your hourly rate if an hourly employee; AND
4. You are working a minimum of 20 hours per week if hired as a full-time employee or averaging a minimum of 17.5 hours per week if hired as a part-time employee; AND
5. You are meeting any additional eligibility requirements of your school district.

When all of these criteria are met, you may be considered an active and eligible participant of the health plan. However, if a participant is not actively working on the effective date of coverage, coverage will be delayed for the participant and his/her dependents until the participant begins work as a new hire or returns to work as a rehire. All required enrollment forms must be submitted within 30 days of becoming an eligible employee.

Active Employees

An eligible employee who is currently enrolled in the District's health plan may choose to elect other coverage options offered by the school district (if applicable) during the open enrollment period with an effective date of July 1; OR

An eligible employee who is currently NOT enrolled in the District's health plan may choose to elect coverage from the options offered by the school district during the open enrollment period with an effective date of July 1.

See "How to Enroll" section for other enrollment eligibility.

Ineligible Subscribers Include:

- Employees working fewer than the required hours listed in the New Hire / Re-hire section above;
- An employee in the employer's probationary period (if applicable);
- Individuals paid for periodic services, such as consultants;
- Temporary employees;
- Volunteers;
- Subcontractors.

Retired Participants

The retired participant may select any package of coverages for Medical, Dental or Vision as long as the coverages are offered to all participants in his/her bargaining unit. Rx coverage is only available with Medical coverage.

The following parameters apply to retired participants:

1. A retired participant may elect to continue coverage in the plan on or before his/her effective date of retirement.
2. The participant must have had Genesee Area Healthcare coverage with his/her employing district for no less than 12 full months before retirement in order to continue coverage.
3. An employee of a participating district, who has Genesee Area Healthcare coverage at or after retirement and drops his/her coverage, may only return if the retiree experiences one of the following changes in family status/qualifying events:
    - Divorce of participant
    - Death of participant's spouse
    - Taking of an unpaid leave of absence by spouse
    - Involuntary termination of health insurance benefits

    The retired employee must notify the plan of his/her desire to re-enter the plan within 30 days of the qualifying event.
4. If a retired participant should die, a surviving spouse will have 30 days from the date of the death to elect continuing coverage under the plan. Non-election by the surviving spouse will render him/her ineligible to remain on or re-enter the plan at a later date.

Dependent

1. Wife or husband. There is **no coverage** for Domestic Partnership.
2. Dependent Children Covered to Age 26. This Rider applies to coverage of children as follows:
    A. If you select a policy other than individual coverage, your children who are under the age of 26 may be covered under the Health Plan. Coverage lasts until the end of the month in which the child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. Children-in-law (spouses of children) and grandchildren are not covered under this Rider.
    B. "Children" include your natural children, a legally adopted child; a step child; and a child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption period. Coverage lasts until the end of the month in which the child turns 26 years of age.
    C. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order is covered. Coverage lasts until the end of the month in which the child turns 26 years of age.
    D. The provisions of any Rider to the Health Plan that extends coverage for young adults through age 29 (for example, the provision requiring that the child be unmarried) shall remain in effect for children ages 26 through 29 and are not changed by provisions set forth above in Paragraphs 2A through 2C that apply to children under the age of 26.
3. A child who is mentally or physically incapable of earning his/her own living could be continued as a dependent beyond age 26, provided proof of the child's incapacity is submitted on the Adult Disabled Dependent Form for medical review and approved by Excellus BCBS.

The term "children" shall include step-children, legally pre-adopted/adopted children, or foster children permanently residing in the participant's household and principally dependent upon the participant for maintenance and support. All grandchildren or non-related children require documentation showing proof of legal custody or guardianship.

If a participant should die, a surviving dependent will have 30 days from the date of the death to elect continuing coverage under the plan. Non-election by the surviving dependent will render him/her ineligible to re-enter the plan at a later date.

How to Enroll

You elect coverage by completing an enrollment form provided by your employer. You are eligible to enroll only:

- during open enrollment or your initial enrollment period based on start date,
- due to divorce or legal separation,
- if spouse involuntarily loses coverage through his/her employer,
- due to death of the participant.

Check with your district to find out when your coverage begins.

Changing your Coverage

If you need to add a spouse or child to your coverage, you must complete and return to your district an enrollment form and any requested documentation. The addition of a spouse or child will be effective as of the date of marriage, birth or adoption (or beginning of adoption proceedings) or other event making the child eligible for coverage, **as long as you return to us a completed enrollment form and requested documents within 30 days of the marriage, birth or adoption or other event.**

When Coverage Ends

Your coverage will end on the earliest of the following:

- The date your eligibility ends, as determined by your employer.
- When you are no longer an eligible employee.
- When you stop making contributions (if applicable).
- When your employer cancels their group coverage.

When you are no longer an active employee, you may continue alternative coverage on an individual basis.

Coverage for all your dependents ends when your coverage ends, or when you stop making contributions, (if applicable), whichever happens first. See section on COBRA.

Removing a Dependent

You may voluntarily remove a dependent at any time during the year as you do not need to wait until open enrollment. Voluntary terminations must be submitted 30 days in advance. Once terminated, you must wait until open enrollment to add dependents back to your coverage.

Removing a Spouse Due to Divorce

Removing a spouse due to divorce requires a copy of the divorce decree provided to you by the court when your divorce is finalized. You must provide a copy of the divorce decree to the GAHP office within 30 days of the final judgment of the divorce so we may remove your ex-spouse from your insurance policy. Ex-spouses are ineligible dependents on our policies. Your ex-spouse will be removed as of the file date provided on the divorce decree.

Disability

Your employer may continue coverage when you are away from work because of a disability. The limits will be determined by your employer. If you become Medicare eligible because of a disability, see section on Medicare.

Temporary Layoff or Leave of Absence

Your employer may continue coverage if you are away from work due to a temporary layoff or leave of absence. The limits will be determined by your employer.

Medicare

Medicare provides a baseline level of healthcare coverage and your GAHP coverage is intended to supplement Medicare. Medicare benefits are for retired participants age 65 or older, or you may be eligible for Medicare earlier if you have a disability, End-Stage Renal Disease, or ALS (also called Lou Gehrig's disease).

Individuals eligible for Medicare are responsible for ensuring they enroll in Medicare Part A and Part B. Contact your local Social Security office or go online to Medicare.gov to **enroll in Medicare 2 to 3 months prior** to reaching age 65. By enrolling prior to reaching age 65, it ensures your coverage begins on the first day of the month you turn 65, preventing any potential coverage gaps. Once you receive your Medicare card, provide your district with a copy of it along with the Medicare Eligibility form you receive from Excellus BCBS.

Failure to enroll in Medicare Part A and Part B when eligible, and no longer actively working, will result in higher costs for the participant as the GAHP plan will not cover the cost of medical services that would have been covered by Medicare if enrolled. See Medicare Coordination of Benefits for more information.

Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), you can delay enrolling in Medicare, if you are an eligible employee still working at age 65 or older, or a dependent age 65 or older of a subscriber who is still working. See TEFRA/DEFRA section on page 19 for more information.

COBRA Initial Notice

Your school district will assist you in determining if and when you are eligible for COBRA and will provide any required COBRA notices when a qualifying event occurs.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires employers with 20 or more employees to offer continuation of group health coverage to "qualified beneficiaries" when coverage would otherwise end because of a "qualifying event". After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the following qualifying events:

- Termination of employment for any reason other than gross misconduct (36 months);
- Reduction in hours causing loss in coverage (36 months);
- Death of the employee (36 months);
- Divorce or legal separation (36 months) employee required to notify school district;
- Dependent children who become ineligible for coverage due to age limitation (36 months) employee required to notify school district;
- Employee becomes entitled to Medicare benefits (under Part A, Part B or both) employee required to notify school district;
- Qualified beneficiaries with a disability (36 months) employee required to notify school district.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the GAHP, and that bankruptcy results in the loss of coverage of any retired employee, retired employee's spouse, surviving spouse, and dependent children covered under the Plan, they will become a qualified beneficiary.

Qualified beneficiaries are required to complete the enrollment form provided to them by their school district in order to be enrolled for any COBRA qualifying event. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. At the end of the COBRA continuation period, a qualified beneficiary may choose to purchase alternative coverage on an individual basis.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Benefits department at your school district.

YOUR BENEFITS

Your Preferred Provider Organization (PPO) shares the cost with you for covered services. The following pages explain how shared payments work and your cost share for covered services.

In-Network

When you receive care or treatment from a provider (hospital, doctor or other healthcare provider) who or which is part of the PPO Network, covered services are generally covered at 80% of allowed charges, subject to the deductible, or a $30 PCP/$35 Specialist copay per visit. **Please see page 7 for 1/1/26 in-network benefit changes.**

Out-of-Network

A hospital, doctor or other health care provider that does not have an agreement with any BlueCross and/or BlueShield PPO Plan. When you receive care or treatment from an out-of-network provider, covered services are generally covered at 60% of allowed charges, subject to the deductible.

Annual Deductible

The annual deductible for in-network and out-of-network combined is $750 per member, $1,500 for 2-person, and $2,250 family maximum per calendar year. Once the deductible is met, the plan then pays 80% of allowed charges for in-network and 60% of allowed charges for out-of-network until your annual out-of-pocket maximum is met. For family coverage, each family member is only subject to the per member annual deductible. Any combination of family members can satisfy the family annual deductible.

Annual Out-of-Pocket Maximum

The annual out-of-pocket (OOP) maximum for in-network and out-of-network will accumulate separately. The in-network out-of-pocket maximum will be $2,250 per member, $4,500 for 2-person and $6,750 family maximum per calendar year. The out-of-network out-of-pocket maximum will be $2,475 per member, $4,950 for 2-person and $7,425 family maximum per calendar year. All cost shares will accumulate to the out-of-pocket maximum for either in-network or out-of-network, to include deductibles, coinsurances, office visit copayments and prescription copayments. Once the out-of-pocket maximum is met for in-network, then the Plan pays 100% of allowed charges of most covered services for the remainder of the year. Once the out-of-pocket maximum is met for out-of-network, then the Plan pays 100% of allowed charges of most covered services for the remainder of the year. For family coverage, each family member is only subject to the single annual out-of-pocket maximum (in-network and/or out-of-network). Any combination of family members can satisfy the family annual out-of-pocket maximum. There are certain out-of-network benefits that will still accumulate towards the in-network annual out-of-pocket maximum. See Benefit Summary pages 1-6 as noted (**).

What Your Plan Coverage Pays

Your coverage pays either 80% of allowed charges subject to the deductible or a copay, where applicable, for eligible in-network expenses, or 60% of allowed charges, subject to the deductible, for out-of-network expenses.

Inpatient Hospital Care

When it is medically necessary for you to be hospitalized, you are covered for unlimited days of inpatient care in a hospital. This includes detoxification. The Plan pays the charge for semi-private room and board, general nursing care, and services and supplies provided and billed by the hospital while you are an inpatient. These benefits include the use of operating, recovery and delivery rooms. A private room is covered if medically necessary, subject to review by Excellus BCBS.

Medical Care as an Inpatient

When it is medically necessary for you to be hospitalized, your coverage pays for medical visits by a physician while you are a registered bed patient. Your medical care coverage is for unlimited days, the same as your inpatient hospital benefits.

Inpatient Mental Health Care and Chemical Dependency

When it is medically necessary for you to be hospitalized, your coverage provides mental health and chemical dependency care. Your coverage pays the charge for semi-private room and board, general nursing care, and services and supplies provided and billed by the hospital/institution while you are inpatient.

Inpatient Skilled Nursing Facility Care

When it is medically necessary for you to be in a Skilled Nursing Facility (SNF), your coverage provides 120 inpatient days for SNF care. Your coverage pays the charge for semi-private room and board, general nursing care, and services and supplies provided and billed by the SNF while you are an inpatient. Custodial care is not covered.

Home Care

When your doctor prescribes care by a home health agency you are covered for home care services. All home health care must be arranged by the home health agency. The plan covers:

- Nursing care;
- Physical therapy and occupational therapy;
- Visiting health aide — provided only as long as personal care assistance is required. This is not for housekeeping, meal preparation or companion services;
- Social casework — personal/family problems, long-term planning;
- Speech evaluation and therapy;
- Complete laboratory tests;
- Hospital equipment, medical supplies and drugs;
- Inhalation therapy and intravenous therapy;
- Transportation of patients and equipment;
- Ambulance.

Hospice Care

As an alternative to hospital care, hospice care is covered at 80% if service is rendered by an in-network provider. A hospice program provides care for the terminally ill on a 24-hour-a-day basis.

Maternity Care: Hospital Billed

Your maternity coverage includes care for a normal pregnancy, complications of a pregnancy, an ectopic pregnancy, caesarian section, or miscarriage and provides for maternity care for dependent children.

Your maternity benefits pay the charge for semi-private room and board, general nursing care, and services and supplies provided and billed by the hospital while you are an inpatient. Maternity coverage is provided for 48 hours for normal delivery and 96 hours for a cesarean section. The mother may opt to leave the hospital earlier than the 48 or 96 hours and can request one covered home care visit. The home care visit must be provided within 24 hours after discharge or at the mother's request, whichever is later.

Maternity Care: Physician Billed

Medical and surgical coverage for maternity care includes care for normal pregnancy, complications of a pregnancy, an ectopic pregnancy, caesarian section, or miscarriage, and provides for maternity care for dependent children. Maternity care includes prenatal care, postnatal care and anesthesia.

Coverage For Newborns

Your Plan coverage provides for routine newborn nursery care services, premature infants and infants with congenital conditions or illness requiring care in excess of routine newborn nursery care.

Routine Adult Physicals

One annual routine physical per calendar year and related lab tests are covered in full if service is rendered by an in-network provider. An out-of-network provider is covered at 60% of allowed charges, subject to the deductible.

Mammography Screenings

Covered in full if service is rendered by an in-network provider for both routine and diagnostic. Out-of-network provider covered at 60% of allowed charges, subject to the deductible.

Well Child Visits

Your plan benefits will cover well child visits, immunizations, laboratory tests and other services ordered at the time of the visit at 100% of allowed charges, based on the Academy of Pediatrics standards. (For children ages 1 and older one visit per calendar year)

Outpatient Mental Health Care

$30 copay per visit for outpatient mental health care when rendered by an in-network provider. Out-of-network providers are covered at 60% of allowed charges, subject to the deductible.

Outpatient Chemical Dependency

$30 copay per visit for outpatient chemical dependency care when rendered by an in-network provider. Out-of-network providers are covered at 60% of allowed charges, subject to the deductible.

Surgical Care

The Plan pays for surgical procedures and the necessary care by the physician before and after the operation. Surgical care also includes the correction of fractures and dislocations.

Second Surgical Opinion

Your Plan coverage pays for a second opinion for proposed non-emergency surgery. The second opinion must be given by a surgeon certified by the appropriate state agencies.

Anesthesia

Your coverage pays for the administration of anesthesia in connection with surgery, maternity care and other covered services.

Emergency Services

Life-threatening and urgent medical emergencies covered in-network and out-of-network with a $250 copayment per visit unless admitted as an inpatient to the hospital within 24 hours.

Urgent Care Services

Freestanding Urgent Care Centers covered with a $35 copay per visit for in-network; covered at 60% of allowed charges, subject to the deductible, for out-of-network services. **Please see page 7 for 1/1/26 urgent care benefit changes.**

Ambulance Service

Ground Ambulance is a $75 copay.
Air Ambulance is covered with coinsurance, subject to the deductible.

Emergency transportation services by a professional ambulance to or from the hospital or by a regularly scheduled airline, railroad or air ambulance to the nearest hospital qualified to provide necessary treatment, and other medically necessary ambulance transportation to and from a medical facility.

PROVIDER REIMBURSEMENT

Care by an In-Network Provider

According to contractual agreement with participating providers.

Care by an Out-of-Network Provider

According to usual and customary charge. The usual and customary charge is a fee or charge by most providers with similar training and experience for a particular service, procedure, or health care item in the geographic area where the service is rendered. Any additional amount billed by the physician is your responsibility.

EXPERIMENTAL AND/OR INVESTIGATIONAL

Experimental and/or investigational means any medical treatment, procedure, drug, substance or device:

- that is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis;
- for which a written protocol or protocols or written informed consent, used by the treating facility or provider, (or the protocol(s) or written informed consent of another facility or provider studying substantially the same medical treatment, procedure, drug, substance, or device), identify the medical treatment, procedure, drug substance or device as a research or investigational or experimental study or a clinical trial;
- that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration ("US FDA") and approval for marketing has not been given at the time the drug or substance or device is furnished;
- that is a drug or substance or device which is not, at the time it is furnished, approved by the US FDA for the specific diagnosis for which the patient is being treated;
- that is a drug or substance or device which is labeled: "Caution-limited by federal law to investigational use" or a substantially similar label or warning.

Any experimental and/or investigational medical treatment defined above is not a covered benefit.

BLUECARD PROGRAM

The Excellus BlueCross BlueShield partnership with the National Blue Cross Blue Shield Association enables you to take advantage of the largest network of participating providers in the country. *This unique national partnership is called the BlueCard Program.*

Blue Cross Blue Shield participating provider networks throughout the United States are available to you through the BlueCard Program. No matter where you live, work, or travel, you can take advantage of the national BlueCard network.

GAHP has contracted with Excellus BlueCross BlueShield to administer your medical care benefits plan. Excellus BlueCross BlueShield has partnerships with other BlueCross BlueShield Plans around the country to see that employees and their families, living outside the Rochester region, are also covered through your employer's plan with Excellus BlueCross BlueShield.

When you use participating providers, you save because fees for participating providers are paid as in-network benefits.

Access to Physician and Hospital Networks

Whether you live in Washington D.C. or Phoenix, Arizona; or your son or daughter is heading to college in Buffalo; or you're planning a vacation in Miami, you can take advantage of the BlueCard Program.

Coast-to-Coast Network

More than 80% of all hospitals and physicians throughout the United States contract with independent Blue Cross Blue Shield Plans. This is now **your** network through the BlueCard Program. Only BlueCard members have access to this vast provider network of traditional participating providers!

Your BlueCard ID card, which is recognized by Blue Cross Blue Shield providers anywhere in the U.S., links you to this vast provider network.

The small "suitcase" on your ID card with "PPO" inside, alerts providers of your membership in the nationwide BlueCard Program.

You have the option of using any provider, regardless of whether they are part of the Blue Cross Blue Shield participating network, but remember, when using providers outside the network, your share of the cost will likely be higher.

International Claims

As an eligible Blue Cross Blue Shield member, you have access to the BlueCross BlueShield GlobalCore program, which allows you to find doctors and hospitals outside of the United States. Information about this program can be found online at www.bcbsglobalcore.com. Additionally, an International Claims Form is attached at the end of this booklet, outlining the process to file claims should you incur medical expenses while traveling abroad.

How to Find a Participating Provider

If you are out of town and get sick, or if you or a family member live outside the Excellus BlueCross BlueShield service region and need to find information about a Blue Cross Blue Shield Plan PPO physician or hospital, just call the local BlueCard PPO Network Doctor and Hospital Information Line at 1-800-810-BLUE (2583). You will receive assistance in locating the nearest PPO network doctor or hospital.

You may also reference the Website at www.excellusbcbs.com/find-a-doctor/provider or download the Excellus BCBS app on your smartphone via the Apple App Store or Google Play Store. In addition, you may always call your Excellus BlueCross BlueShield customer service department by dialing 585-325-3630 or 1-877-253-4797.

It's Simple to Use the Network!

- Visit a Blue Cross Blue Shield Plan Physician and show your ID card.
- The provider quickly verifies your membership and coverage.
- **In most cases, you are responsible to pay the applicable copayment.**
- Providers submit all charges to the local Blue Cross Blue Shield Plan.

Important

Many geographic areas have established specialty networks, such as clinical labs, physical therapists, infusion therapy networks and ambulatory surgical centers. If you are referred to specialty providers, ask ahead if they participate with the PPO Network. The savings you can realize will make it worth your while.

Emergency Care

In an emergency situation, seek medical treatment immediately. Do not be concerned about whether the nearest emergency room is part of the BlueCard participating network.

An emergency is a sudden, serious acute illness, injury or condition, including sudden and severe pain, which could endanger your health if not medically treated immediately.

Hospital Care

When a hospital admission is necessary, you and your doctor most likely will plan in advance where you will go, what needs to be done and how long you will be in the hospital. Remember, in order to obtain maximum benefits, please verify whether you are using in-network or out-of-network providers.

No Claim Forms

There are virtually no claim forms for you to fill out or submit when you receive care from a Blue Cross Blue Shield PPO in-network provider.

However, if you use an out-of-network provider, you may have to pay the bill at the time of service and then file a claim in order to be reimbursed. See additional information on page 20 and claim form at the back of the booklet.

Remember to Always Carry Your ID Card

Providers will need to see your ID card to verify your membership in the BlueCard Program, so it's a good idea to keep it with you at all times. Remember, your card is your link to the BCBS Association Network.

You can also download the Excellus BCBS app to have your ID card at your fingertips.

If you have questions or need information about the BlueCard Program, call Excellus BlueCross BlueShield Customer Service using the toll-free number listed on your BlueCard ID card.

OTHER COVERED SERVICES

- Outpatient surgery, including associated laboratory tests and x-ray services;
- Ambulatory surgery facilities, and services in hospital clinics and one-day surgery centers;
- Medical emergencies and accidental injuries;
- After Hour/Urgent Care Facilities;
- Radiation therapy and Chemotherapy;
- Inhalation therapy, occupational therapy and physical therapy;
- Speech therapy;
- Pre-admission testing within seven days of a hospital admission;
- Laboratory, pathology and x-ray services;
- Home and office care;
- Annual routine GYN exams and pap smears;
- Physician services in the emergency room;
- Ambulance services to the nearest hospital and between hospitals when medically necessary;
- Durable medical equipment, appliances, dressing and medical supplies which are accompanied by a physician's prescription or statement of medical necessity;
- Either eyeglasses, contacts or interocular lenses after cataract surgery;
- Chiropractic services;
- Internal prosthetic devices;
- External prosthetic, custom-made supports and orthopedic braces;
- Dental care as a result of accidental injury to sound and natural teeth occurring after the effective date of your contract. The services must be rendered within 365 days of injury;
- Acupuncture services and related therapeutic treatment rendered by a state licensed acupuncturist;
- In-Vitro Fertilization (IVF) and Fertility Preservation. Coverage is available for three cycles of IVF per lifetime. GIFT/ZIFT services are excluded and are not a part of these benefits;
- 24/7 Nurse Call Line provides support and education for members with chronic or complex health conditions. You can contact a nurse by phone anytime – 24 hours a day, seven days a week with general health questions. Nurse care managers can provide support on the phone or through follow-up educational mailings. Ask a Nurse today – call 1-800-348-9786.

GENERAL EXCLUSIONS

You are not covered for services and supplies that:

- Are not prescribed by a physician or other approved provider;
- Are not considered medically necessary for your diagnosis or treatment;
- Are given to you by a provider other than hospitals, physicians and other approved providers;
- Are experimental or of a research nature (see explanation on page 15);
- Are already covered by another insurance contract;
- Are payments for any illness or injury that happened because of your employment if worker's compensation benefits are available - whether or not you claim those benefits;
- Are payments for any illness or injury that are covered under the mandatory no-fault insurances.

You are not covered for an illness or injury that:

- Is the result of any act of war;
- You would not have a legal obligation to pay.

You are not covered for:

- Inpatient bed rest charges;
- Missed appointments;
- Fees added for filling out a claim form;
- Personal comfort items;
- Radio/television rentals;
- Personal convenience items such as air conditioners, humidifiers, physical fitness equipment and other such devices;
- Custodial care such as sitters, homemaker's services or care in a place that serves you primarily as a residence when you do not require skilled nursing care;
- Services related to routine care of the feet, including but not limited to corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, toenails, or symptomatic complaints of the feet;
- Surgery to improve appearance, except when it is needed to correct certain birth defects or to correct conditions which result from accidental injury or disease;
- Refractions and eye examinations, unless required after Cataract surgery or medically necessary;
- Eyeglasses or contact lenses, unless required after Cataract surgery;
- Transsexual surgery, sex reassignment, unless medically necessary;
- Blood plasma or derivative, except blood for hemophiliac patients;
- Costs already covered by Medicare if Medicare is primary;
- Marriage counseling and all services rendered by a marriage counselor;
- Obsolete procedures;
- Diets and food supplements;
- Care and treatment of the teeth and gums except as previously stated on pages 5 and 17;
- Counseling services and mental health therapy provided by someone other than a licensed psychiatrist, licensed psychologist, or a certified social worker;
- Hearing Aids;
- Charges for GIFT/ZIFT reproductive technologies;
- Routine service other than those listed.

COORDINATION OF BENEFITS

Most group healthcare contracts, including the Genesee Area Healthcare Plan, contain a coordination of benefits provision. This provision is used when you, or your spouse or your covered dependents are eligible for payment under more than one group healthcare contract. The objective of coordination of benefits is to assure you that your covered expenses will be paid, but the combined payments of all the contracts do not amount to more than the actual cost of your care.

Here is how the coordination of benefits provision in your Genesee Area Healthcare Plan coverage works:

When your other group coverage does not mention coordination of benefits, then that coverage pays first. Your Genesee Area Healthcare Plan coverage pays the balance owed for your covered services in accordance with policy provisions.

When the person who receives care is covered as an employee under one group contract, and as a dependent under another and both contracts contain a coordination of benefits provision, then the employee coverage pays first.

When a dependent child is covered under both parents' group contracts, the contract of the parent whose birthday falls earlier in the year is primary and will pay its benefits first. The year of birth is not used in this rule. If both parents have the same birthday, the policy that has been in effect the longest will pay its benefits first. This does not apply to children of separated or divorced parents. The policy of the parent who is legally responsible for providing health coverage for the child will pay its benefits first. If there is no court decree for health care coverage, then the policy of the parent who has custody of the child will pay its benefits first.

If your benefits are coordinated, and you receive more than you should have for the service or care provided, you will be expected to repay any overpayment.

Medicare

When Medicare becomes primary payer, copay is waived on all eligible benefits, except for Ambulance, Emergency Room and TeleMedicine (MDLive) benefits.

When you have both Medicare and the GAHP plan, Medicare is considered the primary payer and GAHP the secondary payer. This means that Medicare will pay first for your covered services and supplies and your GAHP plan will only pay for covered services after Medicare has paid its portion. However, your GAHP coverage and payment amounts are determined by its own plan benefits, not by what Medicare decides to cover or pay. For example, your GAHP plan may cover some services or expenses that Medicare does not, or it may have different copays, coinsurance, or deductibles than Medicare.

TEFRA/DEFRA

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the Deficit Reduction Act of 1984 (DEFRA) applies to subscribers who are over 65. The Genesee Area Healthcare Plan is required to remain primary as long as:

- you are actively working and an eligible employee of the district; and
- your employer employees 20 or more employees; and
- you are entitled to Medicare for the following reasons:
    - you or your dependent are disabled
    - you or your dependent are age 65 or older

which means you can delay enrolling in Medicare until you are no longer considered an active and eligible employee of your district.

Subrogation

In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident and we pay benefits as a result of that injury or illness, we will subrogate and succeed to your right of recovery against the party responsible for your illness or injury to the extent of the benefits we have paid. This means that we have the right, independently of you, to proceed against the party responsible for your injury or illness to recover the benefits we have paid.

CLAIMS

If You Have Questions on a Claim

Please contact your Dedicated Customer Service Team at Excellus BCBS toll-free at 877-253-4797.

Where to Find a Claim Form

You can find and print a claim form online at http://excellusbcbs.com/gahp

How to File a Claim

Participating hospitals, skilled nursing facilities and physicians will submit the claim directly to the local Blue Cross Blue Shield Plan when you show them your identification card. Your Blue Cross Blue Shield identification card provides claim filing instructions for providers of care.

Claims not filed by the provider, such as durable medical equipment, should be sent directly to Excellus BlueCross BlueShield Rochester Region.

Claim filing limit is 12 months from date of service.

Where to File a Claim

Submit the completed claim form and itemized bills to:

Vice President of Claims
P.O. Box 21146
Eagan, MN 55121-0146

Explanation of Benefits (EOB)

After your claim is processed, you will receive an Explanation of Benefits (EOB) statement from Excellus, which may be viewed online with an Excellus BCBS online account. The EOB indicates what action was taken on your claim, specifically, which services were covered and which, if any, were not.

How to Read an Explanation of Benefits Statement (EOB)

You will receive an EOB whenever you render a medical claim. You can view your EOB online by signing in to your subscriber account using your subscriber ID at www.excellusbcbs.com. For dental claims, you will receive an EOB in the mail whenever a claim has been processed. Here is what you will find on your EOB:

- Your name and address;
- Your identification number and the name of the patient;
- The date the service was provided;
- The type of service that was rendered;
- The total amount charged for that service;
- Any amount of the total charge that was not a covered expense;
- The total covered expenses;
- The amount of the covered expense applied to your deductible, if applicable;
- The copayment;
- BCBS total payment;
- Payment summary.

The EOB lists a claim number or a transaction number. Please have this number and the EOB statement available when you call Excellus BCBS Customer Service with questions.

In addition to having access to an online version of the EOB, you will receive a Monthly Health Summary (MHS) in the mail whenever you render a medical claim in that month.

INTERNAL CLAIMS APPEAL PROCEDURE

If a claim for benefits is denied either in whole or in part by Excellus BCBS, you will receive an Explanation of Benefits statement explaining the reason for the decision. You may request further explanation of this decision by calling or writing Excellus BCBS Customer Service Department.

If you are not satisfied with the explanation given to you by our Customer Service Department, you may appeal a denial of benefits for any claim or portion of a claim by sending a written appeal along with any additional information to:

Vice President of Claims
P.O. Box 21146
Eagan, MN 55121-0146

This written appeal must be made within sixty (60) days after you have been notified of the denial of benefits.

A further review will be made of all the facts on which the original decision was based and also any additional information you have provided.

You will be informed of the decision within sixty (60) days, unless additional materials are requested in a timely fashion by Excellus BCBS.

EXTERNAL CLAIMS APPEAL PROCEDURE

You may file an application for an external appeal by a state approved external appeal agent if you have received a denial of coverage based on medical necessity or because the service is experimental and/or investigational.

To be eligible for an external appeal, you must have received a notice of final adverse determination as a result of the BlueCross BlueShield internal appeal process (first level of the plan's internal appeal process) OR they must have jointly agreed to waive the internal appeal process.

You may obtain an external appeal application:

- from the New York State Insurance Department at 1-800-400-8882, or its website **(www.ins.state.ny.us);**
- from the New York State Department of Health at (518) 486-6074, or its website **(www.health.state.ny.us); or**
- by contacting Excellus BlueCross BlueShield.

The application will provide clear instructions for completion. A fee of $50.00 may be required to request an external appeal. This money will be refunded if the external appeal is decided in your favor. You may obtain a waiver of this fee if you meet the Excellus BlueCross BlueShield criteria for a hardship exemption.

The application for external appeal must be made within sixty (60) days of your receipt of the notice of final adverse determination as a result of the Excellus BlueCross BlueShield appeal process or within sixty (60) days of when they jointly agree to waive the internal appeal process.

You will lose your right to an external appeal if you do not file an application for an external appeal within sixty (60) days from your receipt of the final adverse determination from the internal appeal. A final adverse determination is the determination of the healthcare plan's first level of internal appeal. You cannot be required to seek a second level of internal appeal with your health plan in order to request an external appeal.

The application will instruct you to send it to the New York State Department of Insurance. You (and your doctors) must release all pertinent medical information concerning your medical condition and request for services. An independent external appeal agent approved by the State will review your request to determine if the denied service is medically necessary and should be covered. All external appeals are conducted by clinical peer reviewers. The agent's decision is final and binding on both you and Excellus BlueCross BlueShield.

An external appeal agent must decide a standard appeal within thirty (30) days of receiving your application for external appeal from the State. Five (5) additional business days may be added if the agent needs additional information. If the agent determines that the information submitted is materially different than considered by Excellus BlueCross BlueShield, they will have three (3) additional business days to reconsider or affirm their decision. You will be notified within two (2) business days of the agent's decision.

You may request an expedited appeal if your doctor can attest that a delay in providing the recommended treatment would pose an imminent or serious threat to your health. The external appeal agent will make a decision within three (3) days for expedited appeals. Every reasonable effort will be made to notify you and Excellus BlueCross BlueShield of the decision by phone or fax immediately. This will be followed immediately by a written notice.

GLOSSARY

Allowed charges:
The charge that the plan determines is reasonable for covered services provided to you. The reasonable charge for a contracting provider is established by the agreement between the provider and Excellus BlueCross BlueShield.

Ambulatory surgery facility:
A facility with an organized staff of physicians that:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
- Provides nursing services and other treatments by or under the supervision of physicians whenever the patient is in the facility;
- Does not provide inpatient accommodations;
- Is not, other than incidentally, used as an office or clinic for the private practice of a physician or other professional.

Claim form:
A form you must file to receive benefit payments that are due you. Claim forms are designed to provide all the information necessary for the prompt, efficient processing of your claim.

Coinsurance:
The percentage of the cost that a member must pay for any services that are subject to coinsurance. For example, the service may have a benefit where GAHP pays 80% of the cost and the member pays 20%.

Contract holder:
An eligible person who has enrolled for coverage.

Coordination of Benefits:
A cost-sharing mechanism through which benefits covered by more than one carrier are coordinated to allow maximum cost effectiveness and minimize multiple payments for a single service.

Copayment:
A flat charge for services rendered by a provider or facility.

Covered family members:
You, your spouse and dependent children covered under the Plan.

Covered service:
A service or supply, shown in the contract and rendered by the provider, for which benefits are provided.

Deductible:
A cost-sharing mechanism that requires you to pay a set amount before your Plan provides payment.

Dependent:
A covered person other than the contract holder.

Diagnostic service:
A test or procedure performed when you have specific symptoms to detect or monitor your disease, illness, or injury. It must be ordered by a physician or other professional provider. Diagnostic services include, but are not limited to:

- X-ray and other radiology services needed for diagnosis of disease or injury;
- Laboratory and pathology services;
- EKGs and EEGs.

Explanation of Benefits (EOB):
The EOB describes the services billed to Excellus BCBS and the amount of payment made. The EOB statement may be viewed online with an Excellus BCBS online account after your claim has been processed.

Home health care agency:
An organization that:

- Provides skilled nursing care and other services on a visiting basis in the covered person's home;
- Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending physician.

Hospital:
A licensed institution primarily engaged in providing:

- Inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis;
- Treatment and care of injured and sick persons by or under the supervision of physicians;
- 24-hour nursing services by or under the supervision of registered nurses.

Identification card:
A card with information necessary for claims processing. Your subscriber identification number is listed on your card. The card is used to identify you or your dependents who are enrolled in the plan.

Medically necessary:
Services or supplies that are required to identify or treat an illness or injury and are:

- Consistent with the symptoms or diagnosis and treatment of the patient's condition;
- Not solely for the convenience of the patient, the provider or the hospital;
- The most appropriate supply or level to safely treat the patient. When treating an inpatient, medically necessary also means that the patient's condition requires that the services cannot be provided on an outpatient basis.

Monthly Health Summary (MHS):
The MHS is a summary that will be mailed to you monthly after any medical claim is rendered within that month. A MHS will also be delivered to you whenever you render a prescription claim where you paid less than the copayment amount for that prescription.

Non-covered:
A service not covered by your plan.

Non-member hospital:
Any hospital with which no agreement has been made with Blue Cross Blue Shield for rendering hospital services.

Out-of-pocket maximum:
A specified dollar amount of copayment, coinsurance, and deductible expenses incurred by a covered person for covered services in a benefit period. Such expense does not include charges in excess of the provider's reasonable charge. When the out-of-pocket maximum is reached, the level of benefits is increased.

Outpatient:
A covered person who receives services or supplies while not an inpatient.

Outpatient mental health facility:
A facility that mainly provides diagnostic and therapeutic services for the treatment of mental illness on an outpatient basis.

Participant:

A person who is eligible to enroll in the group health plan of a participating school district and meets all the criteria as outlined on page 8 under Eligibility.

This Plan also covers eligible retirees and covers anyone required by law, such as active Board members covered by Municipal Law.

Precertification:
Requires the member to ensure the provider has reviewed, with Excellus BCBS, if a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. If not in compliance, the member may be held liable.

Prescription drug:
Any medicinal substance, the label of which, under the Federal Food, Drug & Cosmetic Act, must bear the legend: *Caution: Federal Law prohibits dispensing without a prescription.*

Prior Authorization:
Requires a provider to review, with Excellus BCBS, if a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary prior to service being rendered. Services requiring prior authorization are subject to medical necessity.

Provider:
A hospital, physician, health professional or other facility, licensed under applicable state laws to include the following:

Facilities

- Hospital;
- Ambulatory surgery facility;
- Dialysis facility;
- Home health care agency;
- Outpatient mental health facility;
- Pharmacy or laboratory;
- Skilled nursing facility;
- Chemical dependency treatment facility.

Professionals

- Doctor of Medicine (M.D.);
- Doctor of Osteopathy (D.O.);
- Podiatrist or Surgical Chiropodist (D.P.M. or D.S.C);
- Doctor of Dental Surgery (D.D.S.);
- Chiropractor (D.C.);
- Nurse Practitioner;
- Physical Therapist (D.P.T., P.T.);
- Clinical Psychologist;
- Registered Nurse (R.N.);
- Licensed Practical Nurse (L.P.N.);
- Licensed Speech Therapist (S.P.);
- Licensed Occupational Therapist (O.T.);
- Certified Social Worker.

Psychiatric hospital:
A facility that mainly provides diagnostic and therapeutic services for the inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Psychologist:
A licensed clinical psychologist. In states where there is not a license law, the psychologist must be certified by the appropriate professional organization.

Skilled nursing facility:
A facility that mainly provides inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of an organized staff of physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

- Minimal custodial, ambulatory, or part-time care;
- Treatment for mental illness, alcoholism, chemical dependency or pulmonary tuberculosis.

Substance abuse treatment facility:
A facility providing detoxification and/or rehabilitation treatment for alcoholism or chemical dependency.

Surgery:

- The performance of generally accepted operative and other invasive procedures;
- Usual and related pre-operative and post-operative care;
- The correction of fractures and dislocations;
- Other procedures as approved by the Plan.

Telehealth:
Telehealth means being able to see **your doctor**, through a virtual visit, if available through your provider.

Telemedicine:
Telemedicine allows a patient to contact and receive healthcare guidance from **a doctor** in real time using a smartphone, tablet, or computer. Telemedicine allows patients to receive health guidance from a physician for non-emergency medical conditions such as cold, flu, allergies, and fever. Additionally, there are psychiatrists, psychologists, and social workers that can help members through a wide range of behavioral health conditions such as depression, stress, and eating disorders.

Usual, Customary and Reasonable Amount:
The amount the Plan determines is reasonable for covered services provided to you. The reasonable amount for a contracting provider is established by the agreement between Excellus BlueCross BlueShield and the provider. In the case of an out-of-network provider, the provider's reasonable amount is the usual, customary and reasonable amount determined by the service area.

DENTAL PLAN RIDERS

Your annual benefit maximums are based on the calendar year and services will follow you throughout the calendar year even when you switch plans mid-year during open enrollment.

Must stay in the dental rider for a minimum of 1 year. However, in order to receive the full orthodontic benefit, you must stay in the dental rider for a minimum of 2 years.

Participating Dentists

Excellus BlueCross BlueShield offers a broad participating dental network in the Rochester, Syracuse, Utica and surrounding areas. You have the option of receiving care from a dentist of your choice. However, choosing a participating dentist may result in savings for you because participating dentists agree to accept our Schedule of Allowances as payment in full for covered services. Aside from any coinsurance, there is no balance billing for covered services when provided by a participating dentist – that's full coverage with no out-of-pocket expense for your covered routine preventive and diagnostic services.

You now have the National GRID Dental + DenteMax Network

National GRID + DenteMax is a network of multiple Blue Cross and Blue Shield Plans that, when combined, offers one of the largest national PPO dental networks and provides patients with lower out-of-pocket costs and broad access to participating dentists.

Non-participating Dentists

Dental Blue plans give you the freedom to see any dentist. **Non-participating** dentists are not obligated to accept our Schedule of Allowances. You will be responsible for balances of **non-participating** dentists' charges.

DENTAL BENEFIT EXCLUSIONS

Coverage under Dental Blue Basic, Dental Blue Select, and Dental Blue Premier will not apply to:

1. Charges for dentures or bridgework (including crowns and inlays forming the abutments) when such charges are incurred for replacement teeth, all of which were extracted prior to the date the individual became a covered employee;
2. Charges for services not considered necessary and appropriate;
3. Charges for replacement of a lost or stolen prosthetic device;
4. Charges for dentistry for cosmetic purposes, including the alteration or extraction and replacement of sound teeth to change appearance;
5. Charges for the replacement of dentures less than 5 years after a preceding placement, except a replacement made necessary by the initial placement of an opposing full denture which necessitates the replacement of an existing denture;
6. Charges incurred for myofunctional therapy, oral hygiene, dietary or plaque control programs or other educational programs;
7. Charges in connection with an injury or illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law.

DENTAL BLUE BASIC BENEFITS

Dental Blue Basic represents a basic plan design to encourage preventive care and early treatment and includes coverage for specialized treatment with a maximum payable in a calendar year of $500 per individual.

Preventive/Diagnostic Services

Preventive and diagnostic services are paid at 50% of BlueShield Fee Schedule. The following are covered under this category:

1. Oral Examination (2 per year)
2. Prophylaxis (2 per year)
3. Dental X-rays;
    a. Full-Mouth Series (once every 3 years)
    b. Bitewings (one set of 4 bitewings per year)
4. Topical fluoride application up to age 16
5. Emergency treatment
6. Sealants to age 17

Restorative Services

All restorative services are paid at 50% of the BlueShield Fee Schedule.

Basic restorative services:

1. Extractions
2. Endodontics (including pulpotomy, pulp capping and root canal treatment)
3. Fillings (consisting of silver amalgam and anterior composite restorations)
4. Oral Surgery (routine extractions, surgical & impacted tooth removal including fracture treatment, cyst removal, and surgical extractions not covered under the medical plan)
5. Periodontics (including gingival curettage, gingivectomy and gingivoplasty)
6. Osseous surgery (bone surgery)
7. IV Sedation for extraction of 3rd molars
8. Repair of dentures

Major restorative services (pre-determination estimates recommended):

1. Prosthodontic (full or partial dentures, fixed or removable bridges, all necessary abutment work, all prosthetic x-rays)
2. Inlays, crowns, porcelain crowns on molars and space maintainers.
3. Implants covered to maximum benefit

Orthodontia Services

1. Initial banding and monthly follow up treatment

For Orthodontia services, no more than $750 per individual up to age 19 will be covered per lifetime. One-half total Orthodontia maximum paid in year one and the other half paid in year two.

Dental Blue Basic Deductible and Maximums

There is a $50 annual individual deductible or a $150 family deductible that applies to restorative services per calendar year.

For all restorative services, the maximum payable in a calendar year shall be $500 per individual. Maximums do not apply to Preventive/Diagnostic services.

DENTAL BLUE SELECT BENEFITS

Dental Blue Select represents an enhanced plan design to encourage preventive care and early treatment, and also includes coverage for specialized treatment.

Preventive/Diagnostic Services

Preventive and diagnostic services are paid at 100% of BlueShield Fee Schedule. The following are covered under this category:

1. Oral Examination (2 per year)
2. Prophylaxis (2 per year)
3. Dental X-rays;
    a. Full-Mouth Series (once every 3 years)
    b. Bitewings (one set of 4 bitewings per year)
4. Topical fluoride application up to age 16
5. Emergency treatment
6. Sealants to age 19

Restorative Services

All restorative services are paid at 50% of the BlueShield Fee Schedule.

Basic restorative services:

1. Extractions
2. Endodontics (including pulpotomy, pulp capping and root canal treatment)
3. Fillings (consisting of silver amalgam and anterior composite restorations)
4. Oral Surgery (routine extractions, surgical & impacted tooth removal including fracture treatment, cyst removal, and surgical extractions not covered under the medical plan)
5. Periodontics (including gingival curettage, gingivectomy and gingivoplasty)
6. Osseous surgery (bone surgery)
7. IV Sedation for extraction of 3rd molars
8. Repair of dentures

Major restorative services (pre-determination estimates recommended):

1. Prosthodontic (full or partial dentures, fixed or removable bridges, all necessary abutment work, all prosthetic x-rays)
2. Inlays, crowns, porcelain crowns on molars and space maintainers.
3. Implants covered to maximum benefit
4. Occlusal Guards

Orthodontia Services

1. Initial banding and monthly follow up treatment

For Orthodontia services, no more than $1,000 per individual up to age 19 will be covered per lifetime. One-half total Orthodontia maximum paid in year one and the other half paid in year two.

Dental Blue Select Deductible and Maximums

There is a $25 annual individual deductible or a $75 family deductible that applies to restorative and orthodontia services per calendar year

For all restorative services, the maximum payable in a calendar year shall be $1,000 per individual. Maximums do not apply to Preventive/Diagnostic services.

DENTAL BLUE PREMIER BENEFITS

Dental Blue Premier represents an enhanced plan design to encourage preventive care and early treatment, and also includes coverage for specialized treatment.

Preventive/Diagnostic Services

Preventive and diagnostic services are paid at 100% of BlueShield Fee Schedule. The following are covered under this category:

1. Oral Examination (2 per year)
2. Prophylaxis (2 per year)
3. Dental X-rays;
    a. Full-Mouth Series (once every 3 years)
    b. Bitewings (one set of 4 bitewings per year)
4. Topical fluoride application up to age 16
5. Emergency treatment
6. Sealants to age 19

Restorative Services

All restorative services are paid at 100% of the BlueShield Fee Schedule.

Basic restorative services:

1. Extractions
2. Endodontics (including pulpotomy, pulp capping and root canal treatment)
3. Fillings (consisting of silver amalgam and anterior composite restorations)
4. Oral Surgery (routine extractions, surgical & impacted tooth removal including fracture treatment, cyst removal, and surgical extractions not covered under the medical plan)
5. Periodontics (including gingival curettage, gingivectomy and gingivoplasty)
6. Osseous surgery (bone surgery)
7. IV Sedation for extraction of 3rd molars
8. Repair of dentures

Major restorative services (pre-determination estimates recommended):

1. Prosthodontic (full or partial dentures, fixed or removable bridges, all necessary abutment work, all prosthetic x-rays)
2. Inlays, crowns, porcelain crowns on molars and space maintainers.
3. Implants covered to maximum benefit
4. Occlusal Guards

Orthodontia Services

1. Initial banding and monthly follow up treatment

For Orthodontia services, no more than $1,500 in the individual's lifetime will be covered. One-half total Orthodontia maximum paid in year one and the other half paid in year two.

Dental Blue Premier Deductible and Maximums

There is a $25 annual individual deductible or a $75 family deductible that applies to restorative and orthodontia services per calendar year

For all restorative services, the maximum payable in a calendar year shall be $1,500 per individual. Maximums do not apply to Preventive/Diagnostic services.

PRESCRIPTION DRUG BENEFIT

Administered by Excellus BCBS FLRx

Must stay in prescription rider for a minimum of one year. If your prescription order for drugs covered under this program are filled at a participating pharmacy, you or your dependents will pay the following co-payments:

Retail (at the pharmacy) *Co-payment applies for each **30-day** prescription*	**Mail Order** *Co-payment applies for each **90-day** prescription*
$5 Generic (Tier 1)	$10 Generic (Tier 1)
$45 Preferred Drug (Tier 2)	$90 Preferred Drug (Tier 2)
$90 Non-preferred Drug (Tier 3)	$180 Non-preferred Drug (Tier 3)

Definitions

Brand Name Drug: A drug that is manufactured and marketed under a trademark or name by a specific manufacturer.

Copayment: The amount charged to a Member by the Participating Pharmacy for the dispensing, including each refill, of a Prescription Drug, before Excellus BCBS will make any payments under this Rider.

Generic Drug: A drug that is chemically equivalent to a Brand Name Drug whose patent has expired and that meets our criteria for designation as a Generic Drug.

Non-Participating Pharmacy: Any pharmacy that dispenses Prescription Drugs and has not entered into a participation agreement with Excellus BCBS. **Excellus BCBS will not pay any benefits under this Rider for Prescription Drugs you purchase at a Non-Participating Pharmacy.**

Participating Pharmacy: Any pharmacy that regularly dispenses Prescription Drugs and has entered into a participation agreement with Excellus BCBS.

Prescription Drugs: Drugs, biologicals and compounded prescriptions that can be dispensed only pursuant to a prescription and that are required by law to bear the legend “Caution - Federal Law prohibits dispensing without a prescription”, or that are specifically designated by Excellus BCBS. The drug or medication must be prescribed by a provider authorized to prescribe and approved by the FDA for the treatment of your specific diagnosis or condition. The drug must also be approved by Excellus BCBS as Medically Necessary treatment of the condition for which the drug is prescribed. In certain situations, specific criteria, including Medical Necessity criteria, may be established by Excellus BCBS and our provider community, defining whether certain drugs will be covered under this Rider. However, if there is a drug that has been approved for the treatment of one type of cancer, Excellus BCBS will also pay for this drug for the treatment of other types of cancer, so long as the drug meets the requirements of New York Insurance Law Section 4303(q).

Prescription Drugs shall include Medically Necessary enteral formulas for which an authorized provider has issued a written order. The written order must state that the enteral formula is clearly Medically Necessary and has been proven effective as a disease-specific method of treatment for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated. Excellus BCBS will also pay for modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism, when provided pursuant to such written order. However, the coverage for modified solid food products is limited to $2,500 per year for such benefits.

Prescription Drugs shall also include Medically Necessary infertility drugs that the FDA has approved specifically for the diagnosis and treatment of infertility and that are prescribed or dispensed in connection with infertility treatment services covered under your contract.

Prescription Drugs include drugs and devices, or their generic equivalents, approved by the FDA for treatment of osteoporosis. Excellus BCBS will apply their standards and guidelines that are consistent with the criteria of the Medicare program or the National Institutes of Health (“NIH”) to determine appropriate coverage for treatment of osteoporosis under this Rider. Excellus BCBS will provide coverage for drugs and devices covered under Medicare or consistent with the NIH criteria. When consistent with Medicare or NIH criteria, coverage, at a minimum, will be provided for those Members:

(1) Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(2) With symptoms or conditions indicative of the presence, or a significant risk, of osteoporosis; or

(3) On a prescribed drug regimen posing a significant risk of osteoporosis; or

(4) With lifestyle factors to the degree of posing a significant risk of osteoporosis; or

(5) With such age, gender and/or physiological characteristics that pose a significant risk of osteoporosis.

Tier One Drug: A Generic Drug that Excellus BCBS designates as a Tier One Drug.

Tier Two Drug: Preferred Brand drugs that are lower costing brand name drugs and tend to be the first course of therapy within the brand name products.

Tier Three Drug: Non-Preferred Brand drugs that are the most costly brand name drugs available. In most cases, if the drug is classified as a Tier 3 drug, it is because there are lower costing therapies available whether it is a generic drug within the same therapy class or other lower costing brand name products or over-the-counter (OTC) products.

Pharmacy Benefits Provided

Drugs From a Participating Retail Pharmacy

(1) If you have a prescription filled with a Tier One Drug, you must pay the retail pharmacy either a $5 Copayment or the cost of the Tier One Drug, whichever is less, for each separate prescription or refill for each 30-day supply of that Tier One Drug. The retail pharmacy will be paid directly by Excellus BCBS for the remainder of the cost of the prescription or refill.

(2) If you have a prescription filled with a Tier Two Drug, you must pay the retail pharmacy either a $45 Copayment or the cost of the Tier Two Drug, whichever is less, for each separate prescription or refill for each 30-day supply of that Tier Two Drug. The retail pharmacy will be paid directly by Excellus BCBS for the remainder of the cost of the prescription or refill.

(3) If you have a prescription filled with a Tier Three Drug, you must pay the retail pharmacy either a $90 Copayment or the cost of the Tier Three Drug, whichever is less, for each separate prescription or refill for each 30-day supply of that Tier Three Drug. The retail pharmacy will be paid directly by Excellus BCBS for the remainder of the cost of the prescription or refill.

Drugs From a Participating Mail Order Pharmacy

(1) If you have a prescription filled with a Tier One Drug, you must pay the mail order pharmacy either a $10 Copayment or the cost of the Tier One Drug, whichever is less, for each separate prescription or refill for each 90-day supply of that Tier One Drug. The mail order pharmacy will be paid directly by Excellus BCBS for the remainder of the cost of the prescription or refill.

(2) If you have a prescription filled with a Tier Two Drug, you must pay the mail order pharmacy either a $90 Copayment or the cost of the Tier Two Drug, whichever is less, for each separate prescription or refill for each 90-day supply of that Tier Two Drug. The mail order pharmacy will be paid directly by Excellus BCBS for the remainder of the cost of the prescription or refill.

(3) If you have a prescription filled with a Tier Three Drug, you must pay the mail order pharmacy either a $180 Copayment or the cost of the Tier Three Drug, whichever is less, for each separate prescription or refill for each 90-day supply of that Tier Three Drug. The mail order pharmacy will be paid directly by Excellus BCBS for the remainder of the cost of the prescription or refill.

For purposes of determining the amount you must pay under Subparagraphs (1) through (3) above, the term “cost” means the rate of payment agreed to between the Participating Pharmacy and Excellus BCBS for a Prescription Drug or the Participating Pharmacy’s actual charge for the Prescription Drug, whichever is less.

Drugs From a Non-Participating Pharmacy

Excellus BCBS will **not** pay for any benefits under this Rider for drugs that you can purchase at a Non-Participating Pharmacy.

Limitations

Prior Authorization

Excellus BCBS will periodically identify certain Prescription Drugs that, for reasons such as cost and possible use for purposes that are not Medically Necessary or appropriate, will only be filled with prior authorization from Excellus BCBS.

(1) **Prior Authorization Procedure:** If you seek coverage for a Prescription Drug that requires prior authorization, your provider will initiate the prior authorization. Your provider must submit a statement of Medical Necessity to Excellus BCBS. After receiving a request for prior authorization, Excellus BCBS will review the statement of Medical Necessity and determine if benefits are available. Excellus BCBS will notify you and your Professional Provider of their decision by telephone and in writing within three business days of receipt of all necessary information. If the Prescription Drug involves continued or extended health care services, or additional services for a course of continued treatment, Excellus BCBS will notify you and your Professional Provider within one business day of receipt of all necessary information.

(2) **Your Right To Appeal:** If you or your Professional Provider disagree with the Excellus BCBS decision, your provider may appeal on your behalf by following the appeal procedures set forth by Excellus BCBS.

(3) **Failure To Seek Authorization:** When you fail to seek prior authorization of a Prescription Drug that requires such authorization and the drug is dispensed, you must pay the Participating Pharmacy for the drug. If you then submit a claim to Excellus BCBS, Excellus BCBS will pay only 50% of the amount that would otherwise have been paid for the Prescription Drug. Excellus BCBS will only pay this amount if determined the Prescription Drug was Medically Necessary, even though you did not seek Excellus BCBS prior authorization. If Excellus BCBS determines that the Prescription Drug was not Medically Necessary, Excellus BCBS will not make any payment for the drug; and you will be responsible for the entire charge.

Excellus BCBS reserves the right to limit quantities, day supply, early refill access and/or duration of therapy for certain medications based on acceptable medical standards and/or FDA recommended guidelines.

Benefits will be provided for drug refills. However, no benefit will be provided for a refill obtained before the date that you should have exhausted most of your current supply. Benefits for refills will not be provided beyond one year from the original prescription date.

Compounded Prescription Drugs will be covered only when they contain at least one ingredient that is a covered legend Prescription Drug, are Medically Necessary, and are obtained from a Participating Pharmacy that is approved for compounding.

A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.

Step Therapy

Medications with step therapy requirements mean that you must first try a certain drug to treat your condition before Excellus BCBS will cover any other drug for that condition. Medication therapy is organized in a series of "steps" with "step one" generally being a generic or lower-cost option and "step two" the higher-cost brand.

Various specific and/or generalized "use management" protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Members with a quality-focused drug benefit. In the event a "use management" protocol is implemented, you will be notified in advance.

This Rider is not intended to duplicate the benefits provided under your medical contract. Examples of prescription coverage provided under your medical contract and therefore not covered under this Rider, include, but are not limited to: injectable drugs (other than self-administered injectable drugs as determined to be Medically Necessary); home infusion therapy; and diabetic insulin and supplies.

Exclusions

Excellus BCBS will not provide coverage for the following:

A. Drugs that do not by law require a prescription, except as otherwise provided in this Rider.

B. Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name as their prescription counterparts.

C. Devices of any type, even though a prescription may be required, except for devices for treatment of osteoporosis. This includes contraceptive devices, therapeutic devices, artificial appliances, hypodermic needles or similar devices.

D. Vitamins, or any herbal product, except those that require a prescription by law.

E. Drugs that are prescribed or dispensed for cosmetic purposes and are not Medically Necessary. Examples of the kinds of drugs that Excellus BCBS often determine to be not Medically Necessary include those prescribed or dispensed for hair growth or removing wrinkles.

F. Drugs that Excellus BCBS determine are prescribed for experimental or investigational use; or that are only available to Members who participate in clinical research programs, unless otherwise required to be covered by external review.

G. Drugs for which benefits are provided under a workers' compensation law or similar legislation.

H. Drugs for which payment is covered by mandatory automobile "no-fault" benefits.

I. Drugs or other pharmacy services provided to you pursuant to a referral prohibited by Section 238-a of the New York Public Health Law. (Generally, Section 238-a prohibits providers from making referrals for pharmacy or other services to a provider, pharmacy or facility in which the referring provider or an immediate family member has a financial interest or relationship.)

J. Drugs dispensed in unit-dose packaging when bulk packaging is available.

K. Drugs given or administered in a physician's office or in an inpatient or outpatient facility.

L. Administration or injection of any drugs.

M. Drugs dispensed to a Member while a patient in a hospital, nursing home, other institution, or a home care patient, except in those cases where the basis of payment by or on behalf of the Member to the hospital, nursing home, home health agency or home care services agency, or other institution, does not include services for drugs.

N. Your benefit for diabetic supplies and equipment is not provided under this Rider. The following diabetic supplies and equipment are not covered under this Rider: blood glucose monitors; test strips; injection aids; syringes; insulin pumps; and insulin infusion devices. Excellus BCBS will also not provide benefits for insulin and oral hypoglycemics under this Rider because they are covered under your base medical contract.

O. Fertility drugs relating to the following infertility treatment services: gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); reversal of elective sterilizations, including vasectomies and tubal ligations; sex change procedures; cloning; and other procedures or categories of procedures excluded by statute.

P. Any contraceptive drugs unless they are prescribed for a medical purpose unrelated to contraception.

General Conditions

A. You must present your identification card to a Participating retail Pharmacy and include your identification number on the forms provided by the Participating mail order Pharmacy from which you make a purchase.

B. As a condition precedent to the approval of claims hereunder, each Member authorizes and directs any Participating Pharmacy that furnishes benefits hereunder to make available to Excellus BCBS information relating to all prescription orders, copies thereof and other records as needed by Excellus BCBS for purposes of administering this Rider. In every case, Excellus BCBS will hold such information and records as confidential.

C. Excellus BCBS conducts various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, your group and its Members benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for your coverage. Excellus BCBS may, from time-to-time, also enter into agreements that result in Excellus BCBS receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drug products across all of Excellus BCBS business and not solely on any one Member's or one group's utilization of Prescription Drugs. Any rebates received by Excellus BCBS may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expense component of our Prescription Drug premiums. Instead, any such rebates may be retained by Excellus BCBS, at their discretion, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of subscribers. Rebates will not change or reduce the amount of any copayment, coinsurance or deductibles applicable under GAHP Prescription Drug coverage.

D. Excellus BCBS will not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of merchantability), arising out of or in connection with the sale, compounding, dispensing, manufacturing or use of any Prescription Drug whether or not covered under this Rider.

E. Excellus BCBS reserves the right to deny benefits for any drug prescribed or dispensed in a manner contrary to normal medical practice.

SPECIALTY MEDICATIONS

Specialty Medications are Prescription Drugs covered under your Prescription Drug Rider that are used to treat conditions such as multiple sclerosis, hepatitis C, rheumatoid arthritis, infertility and growth hormone deficiency; included on the form entitled "List of Specialty Medications" that applies to this Endorsement. Most Specialty Medications are injectables. However, Excellus BCBS' "List of Specialty Medications" also includes select oral medications, compound medications and other types of covered Prescription Drugs.

Excellus BCBS "List of Specialty Medications" may be revised from time-to-time based on the introduction of new drugs and/or new clinical information and after review by Excellus BCBS Pharmacy and Therapeutics Committee. If Excellus BCBS records show that you are taking a Prescription Drug that will be added to the "List of Specialty Medications", Excellus BCBS will notify you in writing at least 30 days in advance of the addition of the drug to the list. A current "List of Specialty Medications" can be obtained on the Excellus BCBS website at www.excellusbcbs.com.

Specialty Pharmacy Networks are retail and specialty pharmacies that have agreements with Excellus BCBS to dispense Specialty Medications to Excellus BCBS members. Excellus BCBS has a list of the pharmacies that participate in the Specialty Pharmacy Network. You may request a copy in writing, by telephone or you may view a copy of the list on the Excellus BCBS website at: www.excellusbcbs.com.

In order to receive coverage for a Specialty Medication under your Prescription Drug Rider, you must obtain the drug from a Specialty Pharmacy Network pharmacy. If you do not comply with this requirement, you must pay the full cost of the Specialty Medication. As described in the paragraph below, the initial fill of a Specialty Medication is the only exception.

The requirements of this Endorsement will not apply to the initial fill of a Specialty Medication. Excellus BCBS will provide coverage for the initial fill of a Specialty Medication as set forth in your Prescription Drug Rider. Thereafter, you must obtain the Specialty Medication through the Specialty Pharmacy Network.

Excellus BCBS will provide benefits for Specialty Medications in a quantity of up to the days' supply limit that, according to your Prescription Drug Rider, or any Rider or Endorsement thereto, applies to Prescription Drugs dispensed by a retail pharmacy.

Benefits under this Endorsement will be subject to the cost-sharing requirements in your Prescription Drug Rider that apply to drugs dispensed by a Participating Retail Pharmacy. Any deductible, copayment or coinsurance that applies to Prescription Drugs dispensed by a Participating Retail Pharmacy that are in the same tier, or of the same type (Generic or Brand Name), as your Specialty Medication(s) will apply to drugs under this Endorsement.

GAHP Annual Disclosure Notices

GAHP HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent, as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within **60 days** of the loss of coverage or the determination of eligibility for premium assistance.

To request special enrollment or obtain more information, contact your school district's designated Benefits Administrator. Any additional questions, contact the GAHP office at 585-344-7566 or 585-344-7564.

Patient Protection Disclosure Notice

Genesee Area Healthcare Plan (GAHP) generally allows the designation of a primary care provider, but IS NOT a plan requirement. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Excellus BCBS at 877-253-4797 or visit Find Care - Blue Cross Blue Shield Association (https://www.bcbs.com/find-a-doctor) and make sure to use prefix: GAH.

For children, you may designate a pediatrician as the primary care provider, but IS NOT a plan requirement.

Please note: you do not need prior authorization from Excellus BlueCross BlueShield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Excellus BCBS at 877-253-4797 or visit Find Care - Blue Cross Blue Shield Association (https://www.bcbs.com/find-a-doctor) and make sure to use prefix: GAH.

WHCRA Annual Disclosure Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact Excellus BCBS at 877-253-4797 for more information.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Excellus BCBS Member Contracts

For more information about your member contract please go to: Excellus BCBS/GAHP or contact Excellus BCBS at 877-253-4797 to request a printed copy.

HIPAA Notice of Privacy Practices

Excellus Privacy Notice: https://news.excellusbcbs.com/documents/d/global/exc-privacy-policy

GAHP Privacy Notice: https://www.gvboces.org/o/gvb/page/hippa-privacy-and-disclosure-notice

Contact Excellus BlueCross BlueShield

FLRx Pharmacy Customer Service

1-800-724-5033
Monday—Thursday 8AM-7PM
Friday 9AM-7PM
Saturday 9AM-1PM

Mail Order

Express Scripts (ESI)

1-855-315-5220

www.express-scripts.com

Wegmans

1-800-586-6910

Medical Specialty Pharmacies

Accredo

1-866-413-4137

Walgreens Specialty Pharmacy

1-866-435-2170

Additional Benefits, Resources and Forms

In addition to the benefits already covered in the preceding pages, the following section contains valuable and pertinent information about different benefits and resources available through Excellus BCBS as part of your Genesee Area Healthcare Plan benefit.

You will find information about the following benefits:

- Creating an online account/ using the Excellus BCBS app
- Blue365
- Wellframe
- Telemedicine

The last few pages in this section provide you with useful forms:

- Authorization to Share Protected Health Information
- International Claim Form
- Medical Subscriber Claim Form

It's your plan. Get more out of it online.

When you sign up for an Excellus BlueCross BlueShield online member account, you get instant access to all your benefits, tools, member-only resources and more.

Member Card(s)
View or order

Claims
Submit, view and download

Find Providers
Find in-network doctors or specialists

Costs and Spending
Estimate medical costs, track deductibles, and view out-of-pocket spending

Benefits and Coverage
View a summary

Get Rewards
Access available spending and rewards programs

Go Paperless

Receive available documents electronically.

Register or log in today

Visit ExcellusBCBS.com

Scan the QR code with your smartphone camera

Take your plan with you 24/7

Download the app!

5 easy steps

It's easy to get started with an online member account.

1. **Have your member card handy**

2. **Visit our website or download our app**

3. **Complete registration**

4. **Choose username and password**

5. **Verify your email**
(Tip: an email will be sent to you during registration)

New member? Or new plan year?

You can register and log in prior to your effective date with limited access to your online account tools until after your effective date.

Thank you for being an Excellus BCBS member!

B-7184/17544-23M REV 07/23

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Excellus BlueCross BlueShield | Blue365

A nonprofit independent licensee of the Blue Cross Blue Shield Association

HEALTHY LIVING IS JUST A DEAL AWAY

Join Blue365 and start saving today!

As an Excellus BlueCross BlueShield member, you have free access to the industry's best health and wellness discounts through Blue365.

Blue365 helps you stay healthy for less with exclusive discounts including:

- Discounted gym memberships with access to over 10,000 gyms nationwide from Tivity Fitness Your Way and Gympass
- Wearable devices from Fitbit, Polar, Garmin and more
- Healthy eating discounts (including Jenny Craig and Nutrisystem)
- LASIK eye surgery, hearing aids and much more

Getting Started

Joining Blue365 and redeeming our deals is easy as 1-2-3. Get started with your free registration at Blue365Deals.com/register

1. **Click the Join or Check Eligibility Button**
   You'll find these at the middle and top right of the Blue365 home page at Blue365Deals.com
2. **Enter Your BCBS Member Information**
   To check your eligibility, simply enter the first 3 characters in your member ID card.
3. **Complete Your Registration**
   Enter your personal information, accept our Terms and you are ready to enjoy our deals!

REGISTER NOW

B-2850 - Oct. 2022

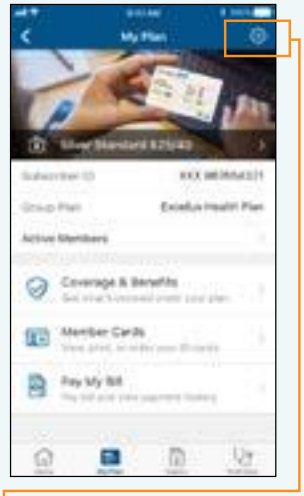
GET READY FOR A MORE CONVENIENT HEALTH CARE EXPERIENCE

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.

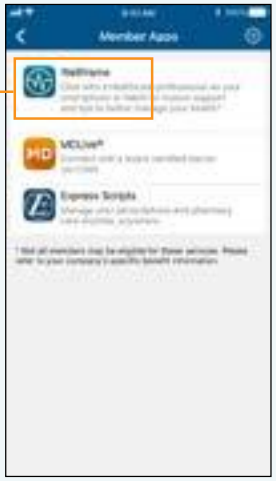
To get started, follow these simple steps:

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

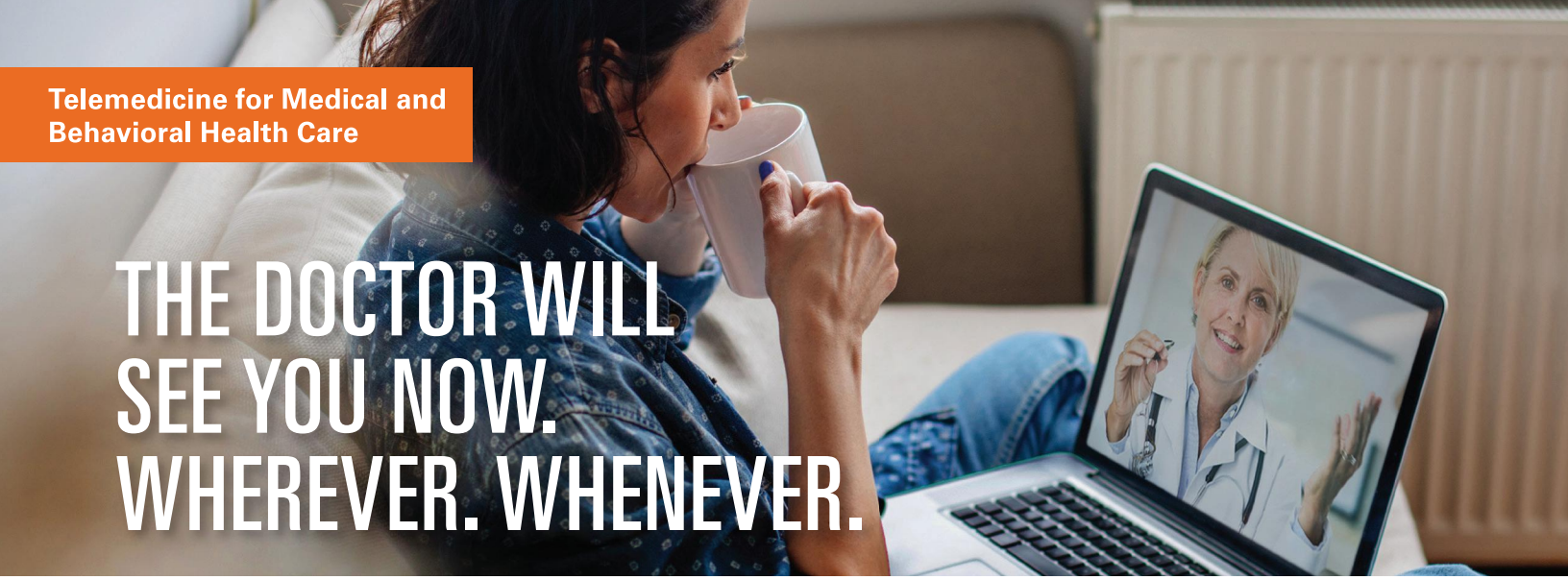
Once you download Wellframe,® you're ready to:

- 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

Download on the App Store | GET IT ON Google Play

Excellus Everybody Benefits

Telemedicine for Medical and Behavioral Health Care



THE DOCTOR WILL SEE YOU NOW. WHEREVER. WHENEVER.

If your doctor isn't available, telemedicine may be an option for you. 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, via your phone, tablet, or computer.

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

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*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.

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

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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

International Claim Form

Please see the instructions on the reverse side of this form before completing.

BlueCross BlueShield Global | Core

Blue Cross and Blue Shield Companies are independent licensees of the Blue Cross and Blue Shield Association.

Send completed form and documentation to: Service Center P.O. Box 2048 Southeastern, PA 19399 or claims@bcbsglobalcore.com
or online at www.bcbsglobalcore.com

1. Patient Information — 1A. Alpha prefix Identification number

Copy this from your Blue Cross Blue Shield identification card.

1B. Patient's name (First, middle initial, last)	1C. Patient's date of birth MM/DD/YYYY	1D. Patient's sex ☐ Male ☐ Female
1E. Name of subscriber (First, middle initial, last)	1F. Subscriber's date of birth MM/DD/YYYY	1G. Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child
1H. Subscriber's current mailing address (Street, city, state, and country or ZIP code)		1I. Patient's e-mail address

2. Other Health Insurance — Is the patient covered under other health insurance, including Medicare A or B? ☐ Yes ☐ No

If yes, complete 2A through 2K below.

2A. Name and address of other insuring company

2B. Type of policy ☐ Family ☐ Individual	2C. Effective date MM/DD/YYYY	2D. Termination date MM/DD/YYYY	2E. Policy or identification number of other coverage
2F. Type of coverage Medical: ☐ Yes ☐ No Hospital: ☐ Yes ☐ No Mental illness: ☐ Yes ☐ No		2G. Name of subscriber	2H. Date of birth MM/DD/YYYY
2I. Employer of subscriber		2J. Employment status ☐ Active employee ☐ Retired employee	

2K. If patient is covered under Medicare, complete the following: Medicare Part A: ☐ Yes ☐ No Effective date _____ Medicare Part B: ☐ Yes ☐ No Effective date _____

3. Diagnosis — 3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury.

3B. Was patient's treatment due to a work-related accident or condition? ☐ Yes ☐ No

3C. Complete for care related to accidental injuries

Date of accident _____ Location: ☐ At home ☐ Auto ☐ Other _____

Time of accident _____ *If the accident was caused by someone else, attach a statement describing the accident.*

4. Charges — Use a separate line to list each type of service or provider and attach itemized bills for all services.

4A. Name and address of provider making charge	4B. Type of provider	4C. Description of service	4D. Dates of service or purchase	4E. Charges

5. Payee — Select one of the following payment options:

Option A. ☐ Make payment to subscriber; provider has been paid.

Select your payment preference: ☐ **Check** – US Dollar ☐ **Electronic Funds Transfer** – US Dollar ☐ **Electronic Funds Transfer** – Currency on itemized bill(s)

If you want to receive an electronic funds transfer provide the following:

Subscriber name as it appears on bank account: _____ Bank name: _____

Bank's Physical Address: _____

Account # /IBAN: _____ Routing # / ABA / BIC / SWIFT: _____

Option B. ☐ Make payment to provider (hospital, doctor), if appropriate. Please complete and sign to authorize direct payment to provider.

I, the undersigned, authorize and request payment for benefits due herein to be made to the following provider of services, if such direct payment is deemed appropriate by the subscriber's Blue Cross and Blue Shield company:

Name of provider _____ Signature of subscriber or spouse _____ Date _____

6. Signature —

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, that participated in any way in the patient's care, to release to the subscriber's Blue Cross and Blue Shield company and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing that applicable law concerning personal information may differ among countries. Authorization is also given to the subscriber's Blue Cross and Blue Shield company and its business associates in any country to collect, use or release any medical or other personal information that they deem necessary to provide service, adjudicate a claim or as otherwise described in such Blue Cross and Blue Shield company's Notice of Privacy Practices.

Signature of subscriber or patient _____ Date _____

General Information

- The Blue Cross Blue Shield Global Core International Claim Form is to be used to submit institutional and professional claims for benefits for covered services received outside the United States, Puerto Rico and the U.S. Virgin Islands.
- **For other claim types (e.g., dental, prescription drugs), contact your Blue Cross and Blue Shield Company for filing instructions.**
- Please complete all fields. If the information requested does not apply to the patient, indicate N/A (Not Applicable).
- Please attach receipts and medical records (test results, x-rays, etc.), if available.
- Please keep photocopies of all documentation for your personal records.

Itemized Bill Information

Each provider's original itemized bill must be attached and must contain:

– The letterhead indicating the name and address of the person or organization providing the service

– The full name of the patient receiving the service

– The date of each service

– A description of each service

– The charge for each service in local currency

SPECIAL CARE SHOULD BE TAKEN WHEN COMPLETING THE FOLLOWING FIELDS:

1. Patient Information

1E. Name of subscriber – For check payments, provide your full name (initials are not acceptable).
1H. Subscriber's current mailing address – If check payment is requested, this address will be used. Please provide your physical address (payments cannot be sent to a P.O. Box).

2. Other Health Insurance

If the patient holds other insurance coverage, please complete items A through K as completely as possible. It is especially important to indicate the name and address of the other insurance company and the policy or identification number of that coverage, as well as the name and birth date of the person who holds that policy.

In addition, if the patient is someone other than the subscriber and has received benefits from any other health insurance plan held by reason of law or employment, the Explanation of Benefits Form furnished by the other carrier pertaining to these charges must be included with the claim. A clear photocopy of the other carrier's Explanation of Benefits Form is acceptable in place of the original document.

4. Charges

Please list the attached bills. Although itemized bills from the provider showing a separate charge for each service must be submitted, your listing will enable us to process the claim more quickly. If additional space is needed, please use a separate sheet of paper to list the following information:

4A. Name and Address of provider — as indicated on the bill. Multiple bills from the same provider may be included on the same line, as long as they are for the same type of service.
4B. Type of provider — for example: hospital, nurse, physician, clinic, physical therapist, etc.
4C. Description of service — for example: hospital admission, office visit, x-ray, laboratory test, surgery, etc.
4D. Date of service or purchase — inclusive dates may be indicated for bills containing multiple dates of service.
4E. Charge —as indicated on the bill. If the bill has already been paid, please indicate the date it was paid.

5. Payee

Option A. Make payment to subscriber, designation of currency and payment method — Please note that not all forms of currency may be available for payment. In the event that you select payment in a currency that is not available, you will be paid in U.S. dollars. Banks may charge a fee to receive a wire. You may want to research fees charged by your bank prior to requesting a wire since you will be responsible for any such fees.

For an electronic funds transfer, provide the bank's physical address where the account was opened (not a P.O. Box). Please provide a copy of a voided check or deposit slip so that the bank information can be validated.

Option B. Authorization for payment to provider — complete option B if you prefer that benefits be paid directly to the provider of service. Direct payment to the provider is at the discretion of your Blue Cross and Blue Shield Company, except where required by law.

6. Signature

The International Claim Form must be signed and dated by the subscriber, spouse, or the patient.

Disclosure Statement

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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PLEASE REVIEW AND LEGIBLY COMPLETE ALL SECTIONS (1-5) OF THIS FORM

***Please Note**-If you do not have all of the required information, please contact the provider of service for assistance prior to submitting your claim. Failure to supply all of the required information may result in delayed processing and/or subsequent return or denial of your claim submission.*

If your address has changed or is incorrect, please call our Customer Service Department at the telephone numbers listed on your identification card.

MEDICAL BENEFITS
SUBSCRIBER CLAIM FORM

Mail completed form and all required information to:

P.O. Box 21146
Eagan, MN 55121-0146

SECTION 1
INFORMATION REQUIRED FROM SUBSCRIBER

1a-HAVE SUBMITTED EXPENSES BEEN PAID IN FULL BY YOU? ☐ YES ☐ NO

***Please Note**-If a participating provider rendered the service(s) being submitted, payment will be made directly to the provider.*

1b-ITEMIZED BILL(S) FOR SERVICES OR SUPPLIES **MUST BE SUBMITTED** WITH THIS FORM IN ORDER FOR REIMBURSEMENT TO BE CONSIDERED. THE ITEMIZED BILL MUST ***CLEARLY*** INDICATE **ALL OF THE FOLLOWING**:

1-PATIENT'S FULL NAME AND DATE OF BIRTH

2-NAME AND ADDRESS OF THE PROVIDER OF SERVICE ON THEIR OFFICE LETTERHEAD, INCLUDING PROVIDER CREDENTIALS AND EIN (TAX) AND/OR NPI NUMBER

3-DATE FOR **EACH** SERVICE RENDERED

4-VALID PROCEDURE CODE (DESCRIPTION OF SERVICES RENDERED) FOR EACH CHARGE

5-CHARGE FOR **EACH** SERVICE RENDERED

6-VALID DIAGNOSIS CODE (DESCRIPTION OF ILLNESS/INJURY FOR SERVICES RENDERED)

7-COUNTRY MUST BE INDICATED AND **ALL** INFORMATION TRANSLATED TO ENGLISH FOR ANY SERVICE(S) NOT RENDERED IN THE USA

8-PRESCRIPTION NUMBER AND NAME OF PRESCRIBING PHYSICIAN MUST BE INDICATED ON RX/MEDICINE BILLS

SECTION 2
SUBSCRIBER /PATIENT INFORMATION

Please enter all information exactly as shown on your ID card

2a-SUBSCRIBER'S LAST NAME	2b-FIRST NAME	2c-INITIAL	2d-SUBSCRIBER IDENTIFICATION NUMBER (Including Prefix)

2e-ADDRESS-NUMBER AND STREET	2f-CITY	2g-STATE	2h-ZIP CODE

2i-PATIENT'S LAST NAME	2j-FIRST NAME	2k-INITIAL	2L-DATE OF BIRTH	2m-GENDER	2n-PATIENT'S RELATIONSHIP TO SUBSCRIBER
			___/___/___ mm dd yyyy	☐ M ☐ F	☐ SELF ☐ CHILD ☐ SPOUSE

SECTION 3
OTHER HEALTH INSURANCE INFORMATION

3a-IS THE PATIENT COVERED BY ANOTHER HEALTH INSURANCE PLAN (INCLUDING MEDICARE)? ☐ YES ☐ NO

***If YES,** please complete 3b-3g below*

3b-NAME OF OTHER POLICYHOLDER	3c-POLICY OR IDENTIFICATION NUMBER

3d-POLICY EFFECTIVE DATE:	3e-TYPE OF POLICY/COVERAGE:	3f-POLICYHOLDER'S DATE OF BIRTH:
___/___/___ mm dd yyyy	☐ INDIVIDUAL ☐ TWO-PERSON ☐ FAMILY	___/___/___ mm dd yyyy

3g-NAME AND ADDRESS OF OTHER INSURANCE CARRIER

***Please Note**-If the patient has other primary insurance, the Explanation of Benefits form(s) from the other health insurance plan must accompany this claim form, along with the matching itemized bill.*

SECTION 4
MOTOR VEHICLE/WORK-RELATED INFORMATION

4a-ARE THE SUBMITTED EXPENSES RELATED, IN ANY WAY, TO A MOTOR VEHICLE OR WORK-RELATED ACCIDENT OR INJURY?

☐ YES ☐ NO

***If YES,** please complete 4b & 4c below*

4b-TYPE OF ACCIDENT: ☐ WORK ☐ MOTOR VEHICLE ☐ OTHER	4c-DATE OF ACCIDENT OR INJURY: ___/___/___ mm dd yyyy

SECTION 5
SIGNATURE AND DATE

I CERTIFY THAT THE INFORMATION SUBMITTED IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE OF ANY RELEVANT INFORMATION TO MY INSURANCE CARRIER.

SUBSCRIBER SIGNATURE: _____ **DATE:** _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, 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 each violation.