ADDENDUM to 2024 Health Benefits Program Notice for Active Joint Sewage Board Employees (Salaried & Management) with a Medicare-covered Spouse and/or Dependent[s]

effective January 1, 2024

For Medicare-covered spouses and dependents of Active Joint Sewage Board Employees:

> An Active Employee's Medicare-covered spouse and dependent[s] with active Medicare Part A and Part B coverage shall be enrolled in an Individual Medicare Blue PPO Copay Plan.

> Employees shall pay 18.0% of health insurance program costs during 2024 for each Medicare-covered spouse/dependent.

> Beginning for services on or after 01/01/2024, reimbursements under the Dental Insurance Policy shall be in accordance with the Excellus Group Dental Policy, subject to a $1,500 annual maximum benefit per person, and a $1,500 lifetime maximum per person for orthodontic services, not more than half of which will be paid in any calendar year.

The "Policies and Benefits for Salaried and Management Staff" is subject to change upon approval by the Binghamton-Johnson City Joint Sewage Board.

The costs and deductions for this plan and included programs/services will change effective January 1, 2024, to the following:

program including AETNA - Medicare Advantage (P01) ESA PPO Copay Plan
with $10/$25/$40 Copay Rx (30-day supply)
$30/$75/$120 Copay Rx (90-day supply)

	INDIVIDUAL
Total Monthly Cost	**$245.94**
82.0% paid by Employer	**$201.67**
18.0% paid by Employee	**$44.27**
Bi-weekly deduction	**$20.43**

Your Medicare-covered spouse and/or dependent's bi-weekly health insurance program premium will be deducted from your pay on a pre-tax basis. If you do not want this pre-tax arrangement, you must file a waiver with the Secretary (Michele) in the Plant Office.

for

Joint Sewage Treatment Plant Health Program Questions:

call: Thomas Augostini **(607) 206-0929** [cell]
Haylor, Freyer & Coon, Inc.
585 Main Street, Suite 1 **(607) 797-2003, extension 2830**
Johnson City, New York 13790 e-mail: <***TAugostini@haylor.com***>

What's Included?

When your Medicare-covered Spouse or Dependent signs-up for the Medicare Advantage PPO Plan, the programs and benefits shown below are also included:

program including
AETNA – Medicare (P01) ESA PPO Plan – see pages* M-1 to M-17 *attached

► AETNA nationwide Medicare Advantage (P01) ESA PPO Plan providing Hospital, Medical, Major Medical, and Medicare Part D PPO Prescription Drug group health insurance coverage (see attached plan description for further information), with

$10/$25/$40 copay* for a 30-day supply and
$30/$75/$120 copay* for a 90-day retail or mail-order supply

* - copays shown are for a "Network Pharmacy"; copays may be less if a "Preferred Pharmacy" is used (*see*, page **M-10** or visit URL: <http://www.aetnaretireeplans.com>).

- $100 Vision Eyewear Reimbursement (once every 12 calendar months)
- Lifestyle and Wellness Benefits (SilverSneakers® Exercise Program, and 1x/week [telephone call, video, or online chat session] Healthy Lifestyle Coaching)
- ability to obtain Claims Assistance / Resolution Services regarding the above programs from AETNA Member Services via a toll-free telephone number or via the *Internet*.

► an insured Dental Expense Program (***see pages D-1 and D-2, and dAPP pages 1 - 4 attached near the back of this notice packet***)

► an insured Vision Expense Program (***see pages V-1 through V-10, attached near the back of this notice packet***)

► access to the employee portal of the Haylor, Freyer & Coon, Inc. employee benefits information website and invitations to attend information/education programs (*after January 2024*)

► with respect to Dental and Vision claims, ability to obtain Claims Assistance/Resolution Services from Haylor, Freyer & Coon, Inc.

If you have questions, or for further information, please contact the person / firm shown at the bottom of the front side of this notice

aetna™

CITY OF BINGHAMTON JOINT SEWAGE BOARD
Aetna Medicare℠ Plan (PPO)
Medicare (P01) ESA PPO Plan
Rx $10/$25/$40 (P1)

Benefits and Premiums are effective January 1, 2024 through December 31, 2024

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	Network & out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Annual Deductible This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	$0
Annual Maximum Out-of-Pocket Amount Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	$750

It will apply to all medical expenses except Hearing Aid Reimbursement, Vision Reimbursementand Medicare prescription drug coverage that may be available on your plan.

HOSPITAL CARE*	This is what you pay for network & out-of-network providers.
Inpatient Hospital Care	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Observation Stay	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay
Outpatient Services & Surgery	$50
Ambulatory Surgery Center	$50

PHYSICIAN SERVICES	This is what you pay for network & out-of-network providers.
Primary Care Physician Visits	$15
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	$15

PREVENTIVE CARE	This is what you pay for network & out-of-network providers.
Medicare-covered Preventive Services	$0

- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings and counseling
- Annual Well Visit - One exam every 12 months.
- Bone mass measurements
- Breast exams
- Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
- Cardiovascular behavior therapy
- Cardiovascular disease screenings
- Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screenings
- Diabetes screenings
- HBV infection screening
- Hepatitis C screening tests
- HIV screenings
- Lung cancer screenings and counseling
- Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.

• Nutrition therapy services • Obesity behavior therapy • Pelvic Exams - one routine GYN visit and pap smear every 24 months. • Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service • Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday) • Sexually transmitted infections screenings and counseling • Tobacco use cessation counseling • Welcome to Medicare preventive visit	
Immunizations • Flu • Hepatitis B • Pneumococcal	$0
Additional Medicare Preventive Services • Barium enema - one exam every 12 months. • Diabetes self-management training (DSMT) • Digital rectal exam (DRE) • EKG following welcome exam • Glaucoma screening	$0
EMERGENCY AND URGENT MEDICAL CARE	**This is what you pay for network & out-of-network providers.**
Emergency Care; Worldwide (waived if admitted)	$65
Urgently Needed Care; Worldwide	$15

DIAGNOSTIC PROCEDURES*	This is what you pay for network & out-of-network providers.
Diagnostic Radiology CT scans	$15
Diagnostic Radiology Other than CT scans	$15
Lab Services	$0
Diagnostic testing & procedures	$0
Outpatient X-rays	$15
HEARING SERVICES	**This is what you pay for network & out-of-network providers.**
Routine Hearing Screening We cover one exam every twelve months	$0
Medicare Covered Hearing Examination	$15
Hearing Aid Reimbursement	$500 once every 36 months
DENTAL SERVICES	**This is what you pay for network & out-of-network providers.**
Medicare Covered Dental*	$15
Non-routine care covered by Medicare.	
VISION SERVICES	**This is what you pay for network & out-of-network providers.**
Routine Eye Exams One annual exam every 12 months.	$15
Diabetic Eye Exams	$0
Medicare Covered Eye Exam	$15
Vision Eyewear Reimbursement Applies to in or out of network	$100 once every 12 months

MENTAL HEALTH SERVICES*	This is what you pay for network & out-of-network providers.
Inpatient Mental Health Care	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care	20%
Individual visit	
Partial Hospitalization	20%
Inpatient Substance Abuse	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Abuse	20%
Individual visit	
SKILLED NURSING SERVICES*	**This is what you pay for network & out-of-network providers.**
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-20; $178 per day, days 21-100
Limited to 100 days per Medicare Benefit Period.	
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.	
PHYSICAL THERAPY SERVICES*	**This is what you pay for network & out-of-network providers.**
Outpatient Rehabilitation Services	$15
(Speech, physical, and occupational therapy)	
AMBULANCE SERVICES	**This is what you pay for network & out-of-network providers.**
Ambulance Services	$65
Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.	

TRANSPORTATION SERVICES	This is what you pay for network & out-of-network providers.
Transportation (non-emergency)	24 one-way trips with 60 miles allowed per trip

MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network & out-of-network providers.
Medicare Part B Prescription Drugs	20%

MEDICARE PART D PRESCRIPTION DRUGS	This is what you pay for network & out-of-network providers.

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.

ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network & out-of-network providers.
Allergy Shots	$15
Allergy Testing	$15
Blood All components of blood are covered beginning with the first pint.	$0
Cardiac Rehabilitation Services	$15
Intensive Cardiac Rehabilitation Services	$15
Chiropractic Services* Medicare covered benefits only.	$15
Diabetic Supplies* Includes supplies to monitor your blood glucose.	$0
Durable Medical Equipment/ Prosthetic Devices*	20%
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Medical Supplies*	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	$15
Outpatient Dialysis Treatments*	$0
Podiatry Services Medicare covered benefits only.	$15
Pulmonary Rehabilitation Services	$15
Supervised Exercise Therapy (SET) for PAD Services	$15
Radiation Therapy*	$15
ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	**This is what you pay for network & out-of-network providers.**
Fitness Benefit	SilverSneakers®
Healthy Lifestyle Coaching One phone, video or chat session weekly.	Covered

Meals	$0
Covered up to 14 meals following an inpatient stay.	
Resources For Living®	Covered
For help locating resources for every day needs.	
Teladoc™	$0
Telemedicine services with a Teladoc™ provider. State mandates may apply.	
Telehealth	Covered
Telemedicine Services. Member cost share will apply based on services rendered.	
Telehealth PCP	$15
Telehealth Specialist	$15
Telehealth Occupational Therapy Services	$15
Telehealth PT and SP Services	$15
Telehealth Other Health care Providers	$15
Telehealth Individual Mental Health	20%
Telehealth Group Mental Health	20%
Telehealth Individual Psychiatric Services	20%
Telehealth Group Psychiatric Services	20%
Telehealth Individual Substance Abuse Services	20%
Telehealth Group Substance Abuse Services	20%
Telehealth Behavioral Health Vendor: MD Live	$0
Telehealth Kidney Disease Education Services	$0
Telehealth Diabetes Self-Management Training	$0
Telehealth Opioid Treatment Program Services	20%
Telehealth Urgent care	$15
Wigs*	$0
Maximum	$400
Frequency	one wig every year

ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Acupuncture unlimited visits every year. in lieu of anesthesia and for treatment of chronic pain.	50%
Cervical and Vaginal Cancer Screening (non-Medicare covered) In addition to the Medicare-covered services listed above, we cover one exam every twelve months	$0
Routine Physical Exams One exam per calendar year	$0

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PHARMACY - PRESCRIPTION DRUG BENEFITS

Calendar-Year deductible for Prescription drugs $0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network P1

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com.)

Formulary (Drug List) Comprehensive Plus

Initial Coverage Limit (ICL) $5,030

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

3 Tier Plan	30-day Supply through Retail		90-day Supply through Retail or Mail		
	Preferred	Standard	Preferred Retail	Preferred Mail	Standard Retail or Mail
Tier 1 - Generic Generic Drugs	$9	$10	$27	$27	$30
Tier 2 - Preferred Brand Preferred Brand Drugs	$25	$25	$75	$75	$75
Tier 3 - Non-Preferred Brand Non-Preferred Brand Drugs	$40	$40	$120	$120	$120

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail pharmacy and you may receive up to a 31 day supply.

Coverage Gap

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage Limit. Your cost-sharing for covered Part D drugs after the Initial Coverage Limit and until you reach $8,000 in prescription drug expenses is indicated below.

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage:	You pay $0.

Catastrophic Coverage benefits start once $8,000 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Applies
Step-Therapy	Applies

Non-Part D Supplemental Benefit

- Agents used for cosmetic purposes or hair growth
- Agents used to promote fertility
- Agents when used for the symptomatic relief of cough and colds
- Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Agents when used for weight loss
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

Medical Disclaimers

For more information about Aetna plans, go to **www.AetnaRetireePlans.com** or call Member Services at toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The provider network may change at any time. You will receive notice when necessary.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

Pharmacy Disclaimers

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

Aetna's pharmacy network includes limited lower-cost, preferred pharmacies in Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, Urban Pennsylvania, Suburban Utah, Suburban West Virginia, Suburban Wyoming. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-866-241-0357 (TTY: 711) or consult the online pharmacy directory at http://www.aetnaretireeplans.com.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Members who get "extra help" don't need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-866-241-0357, 24 hours a day, 7 days a week. TTY users call 711.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. The amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs". These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Your plan includes supplemental coverage for some drugs not typically covered by a Medicare Part D plan. Refer to the "Non-Part D Supplemental Benefit" section in the chart above. Non-Part D drugs covered under the non-part D supplemental benefit can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the plan.

Plan Disclaimers

Aetna Medicare is a HMO and PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.
Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna). Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

The formulary, provider and/or pharmacy network may change at any time. You will receive notice when necessary.
Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.
You can read the Medicare & You 2024 Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711). Traditional Chinese:
注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

You can also visit our website at http://www.aetnaretireeplans.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-307-4830. Someone who speaks English/Language can help you. This is a free service.

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DBOV-1E-26/26	Dental Blue Options	
Plan Overview		
Package ID	DBOV-1E-26/26	
Plan Name	Dental Blue Options	
Plan Type	PPO Voluntary	
Package Status	Existing	
Effective Date	1/1/2024 - 3/31/2024	
Activity Status	Active	
Dental Plan Features		
Dependents and students	Qualified dependents and students are covered to age 26.	
Annual Deductible	$50 Single/$150 Family; applies to classes II, IIA and III	
Annual Maximum	$1,500 applies to classes II, IIA and III	
Annual Maximum Rollover	N/A	
Orthodontia Lifetime Maximum includes dependents to age 19	$1,500 individual maximum. No more than one half of the Lifetime Maximum will be paid in any calendar year.	
Domestic partner	Covered	
Waiting periods & other limitations	Does not apply to members who are timely entrants	
Network Benefits		
	In-Network	**Out Of Network**
In Area	Coverage provided through Excellus BlueShield dental provider network	Covered at fee schedule, subject to balance billing
Out of area	Coverage provided through National Dental Grid+ DenteMax provider network	Covered at fee schedule, subject to balance billing
Plan Benefits		
Class I - Preventive	**In-Network**	**Out Of Network**
Class I - Coinsurance	Covered at 100%	Covered at 100%, subject to balance billing
Cleanings & exams	Covered at 100%	Covered at 100%, subject to balance billing
Fluoride treatments covered to age 16	Covered at 100%	Covered at 100%, subject to balance billing
Sealants	Covered at 100%	Covered at 100%, subject to balance billing
Bitewing x-rays	Covered at 100%	Covered at 100%, subject to balance billing
Full mouth and panorex x-rays	Covered at 100%	Covered at 100%, subject to balance billing
Space maintainers	Covered at 100%	Covered at 100%, subject to balance billing
Emergency palliative treatment	Covered at 100%	Covered at 100%, subject to balance billing
Dental Prophylaxis	Covered at 100%	Covered at 100%, subject to balance billing
Class II - Basic Restorative	**In-Network**	**Out Of Network**
Class II - Coinsurance	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Fillings	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Simple Extraction Oral Surgery	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Class II A - Basic Restorative	**In-Network**	**Out Of Network**
Class II A - Coinsurance	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Oral surgery	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Endodontics	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Periodontal surgery	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Periodontal scaling and root planing	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing

DBOV-1E-26/26	Dental Blue Options	
Periodontal maintenance following surgery	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Class III - Major Restorative	**In-Network**	**Out Of Network**
Class III - Coinsurance	Covered at 50%, subject to deductible	Covered at 50%, subject to deductible and balance billing
Fixed prosthetics	Covered at 50%, subject to deductible	Covered at 50%, subject to deductible and balance billing
Removable prosthetics	Covered at 50%, subject to deductible	Covered at 50%, subject to deductible and balance billing
Inlays / Onlays / Crowns	Covered at 50%, subject to deductible	Covered at 50%, subject to deductible and balance billing
Relines / rebases	Covered at 50%, subject to deductible	Covered at 50%, subject to deductible and balance billing
Implants	Covered at 50%, subject to deductible	Covered at 50%, subject to deductible and balance billing
Class IV - Orthodontia Group must have 5 contracts enrolled	**In-Network**	**Out Of Network**
Class IV - Coinsurance	Covered at 50% to age 19, subject to orthodontia lifetime maximum	Covered at 50% to age 19, subject to balance billing and orthodontia lifetime maximum
Braces	Covered at 50% to age 19, subject to orthodontia lifetime maximum	Covered at 50% to age 19, subject to balance billing and orthodontia lifetime maximum

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

FOR INTERNAL USE ONLY

HIOS ID# _____

EC _____

CONFIDENTIAL

Commercial Group Health Insurance Application/Change Form

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

Section 1: Employer Group & Benefit Information

To be completed with your Group Administrator

Binghamton-Johnson City Joint Sewage Board

Employer Name

Association/Chamber Name (if applicable)

Check Desired Action

☐ Add ☐ Cancel ☐ Change

_____ _____ _____ _____

Group Administrator's Signature (required) Date Employee's ID Number Department Number

Dental Information

_____

Dental Group Number (8 digits)

_____ _____

Dental Subgroup Dental Class

_____ . _____ . _____

Dental Effective Date

Who do you need Dental coverage for?

☐Self Only ☐Family ☐Self & Child(ren)

☐Self & Spouse, or Self & Domestic Partner

Dental Plan Selection

▬ **DBOV-1E-26/26**

(please complete and submit separate application for included Guardian Vision coverage)

Subscriber Status: ☐Actively Working ☐Retired ☐Disabled ☐Canceled ☐COBRA

Section 2: Subscriber's Information

_____

Last Name

_____

First Name

_____ _____

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

_____

Street Address

_____ _____

City **State**

_____ _____

Zip Code **Phone**

Birthdate: _____ . _____ . _____

Gender:
☐Female
☐Male
☐Gender X

Gender identity (optional):
☐Transgender Male
☐Transgender Female
☐Prefer to self-describe: _____
☐Prefer not to say
☐Non-binary

Social Security Number** _____

Date of Hire/Rehire: _____ . _____ . _____

Retirement Date: _____ . _____ . _____

_____ ☐Age 65+ ☐Disability

Subscriber's Medicare Number (if applicable) ☐End Stage Renal *

_____ . _____ . _____ _____ . _____ . _____

Medicare Part A Effective Date **Medicare Part B** Effective Date

Subscriber's Last Name: _____

Section 3: Reason for enrollment or change

To be completed by the Group Administrator **Not required for cancelations**

Enrollment Opportunity: ☐New Hire ☐Rehire ☐Open Enrollment ☐Medicare eligible

Special Enrollment Opportunity: ☐Newly Eligible Dependent: ☐Newborn ☐Marriage ☐Other _____

☐Change in employment status ☐A move in or out of the service area

☐Involuntary loss of coverage ☐Former dependent regains eligibility

Date of Event ___ . ___ . _____

COBRA Election - Please indicate the reason for COBRA if applicable:

☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Spouse

☐Disability ☐Dependent Reached Max Age ☐ Other: _____

Demographic Change: ☐Address ☐Birthdate ☐Subscriber Name ☐Dependent Name ☐Phone Number

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

Subscriber

Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:

Cancel Codes:

SB02-Left Employment SB58-Change in Employee Eligibility Status SB08-Subgroup Transfer*

SB06-Employee No Longer Wants Coverage* (subscriber request) SB57- Layoff Without Benefits

SB07-Deceased SB09-Enrolled in Error* SB44-Medicare Eligible (Moved to Medicare plan with same employer)

* = Not eligible for COBRA

Dependent(s)

* = Not eligible for COBRA

Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:

Cancel Codes:

M002-Deceased* M005-Divorced M010-Overage Dependent M014-YA No Longer Qualifies* M013-Ineligible Dependent

M003-Subscriber No Longer Wants to Cover Dependent* M007-Dependent No Longer Wants Coverage* M009-Marriage

M011-No Longer a Student M004-Enrolled in Error* M008-Moved Out of Area* M040-Medicare Same Group*

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

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent (Separate application form required)

☐Other_____

_____ _____ _____ _____

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

Gender: ☐Female ☐Male ☐Gender X **Birthdate** _____ . _____ . _____

Gender identity (optional): ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ . ___ . ____ Expected Graduation Date: _____ _____ _____

If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

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

_____ Part A Effective Date: ___ . ___ . ____ Part B Effective Date: ___ . ___ . ____

Medicare Number (if applicable)

↓ Additional Dependent(s) ↓

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other_____

_____ _____ _____ _____

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

Gender: ☐Female ☐Male ☐Gender X **Birthdate** _____ . _____ . _____

Gender identity (optional): ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ . ___ . ____ Expected Graduation Date: _____ _____ _____

If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

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

_____ Part A Effective Date: ___ . ___ . ____ Part B Effective Date: ___ . ___ . ____

Medicare Number (if applicable)

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other_____

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

Gender: ☐Female ☐Male ☐Gender X **Birthdate** _____ . _____ . _____
Gender identity (optional): ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe: _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ . ___ . ____ Expected Graduation Date: _____ . _____ . _____
If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No

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

_____ Part A Effective Date: ___ . ___ . ____ Part B Effective Date: ___ . ___ . ____
Medicare Number (if applicable)

Note: Use an additional application [or addendum] if more than three dependents need coverage.

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

Have you or any member of your family been enrolled in other medical or dental coverage? ☐Yes ☐No
If yes, what type of coverage? ☐Medical ☐Dental
What is the effective date of the other coverage? ☐Medical: ____ . ____ . _____ ☐Dental: ____ . ____ . _____
What is the name of the other carrier(s)? _____
Are you keeping the coverage? ☐Yes ☐No
If no, when will the coverage end? ☐Medical: ____ , ____ , _____ ☐Dental: ____ , ____ , _____
Policyholder's name _____ ID#(s) _____
Who did the insurance cover? ☐Self Only ☐Self & Spouse/Domestic Partner ☐Self & Child(ren) ☐Family

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

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

I hereby accept responsibility for payment of any portion of the premium.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

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

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

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature _____ **Date** _____

Please return to P.O. Box 21146 Eagan, MN 55121-0146
If you have questions, please contact your Group Administrator. Or, visit us at: ExcellusBCBS.com

Instructions for completing the Group Health Insurance Application/Change Form

Section 1: Employer Group & Benefit Information

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

Section 2: Subscriber's Information

This section should be completed by the Subscriber.
**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.
* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Gender and gender identity: Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.

Section 3: Reason for enrollment or change

Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

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

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

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

Please include information about all the people who you would like coverage for.
Use an additional application if more than three dependents need coverage.
If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.
Qualified guidelines for coverage include:

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

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.
* There is additional information needed if eligible for Medicare due to ESRD.
A separate Adult Disabled Dependent application form is required for applicable dependents. Please contact your Group Administrator for the appropriate forms.

Section 6: Other coverage information (Required)

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

Section 7: Release

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

Guardian

BINGHAMTON-JOHNSON CITY JOINT SEWAGE BOARD
ALL ELIGIBLE EMPLOYEES
Group Number: 00581589

Customer Service (888) 600-1600
Monday to Friday | 8am to 8:30pm ET

Welcome to
Workplace benefits

Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

Your coverage options

Vision insurance	Looking after your eyesight and related health issues

Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1. Read through this information.
2. Find out more about your benefits.
3. Talk to your employer if you need help or have any questions.

This document is a summary of the major features of the insurance coverage that's been agreed to with your employer – it isn't your contract.

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Guardian®

Watch our video
How vision insurance can help you see clearly as you get older.

Vision insurance

Vision insurance helps protect the health of your eyes by providing coverage for benefits that often aren't covered by regular medical insurance.

Protecting your eyesight means allowing for routine visits to the optometrist for eye exams, as well as coverage for glasses and contacts. Make sure your eyes remain in great shape at any age – no matter how much time you spend staring at digital screens.

Who is it for?

Even if you have perfect eyesight, it's important to have regular eye exams to make sure you're still seeing clearly. Most of us may eventually need vision correction, which is why we offer vision insurance to cover some of the costs.

What does it cover?

Vision insurance covers benefits not typically included in medical insurance plans. It covers things like routine eye exams, allowances towards the purchase of eyeglasses and contact lenses, as well as discounts on corrective Lasik surgery.

Why should I consider it?

Regular eye exams can detect more than failing eyesight, they can also pick up diseases like glaucoma and diabetes. Vision problems are one of the most prevalent disabilities in the United States, making vision insurance especially useful for anyone who regularly needs to purchase eyeglasses or contacts, or anyone who simply wants to help protect their eyesight and general health.

You will receive these benefits if you meet the conditions listed in the policy.

20/20 coverage

David notices that his vision is deteriorating. He goes in for an eye exam, and is diagnosed with myopia, which means he needs glasses.

Average cost of vision exam: **$171**

Average cost of frames and lenses: **$350**

Total cost: **$521**

With a Vision policy from Guardian, David pays just **$10** for his eye exam. After **$25** in copay, his lenses are fully covered, and he pays **$96** for his frames.

David's total out-of-pocket expense is **$131**, saving him **$390**.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

BINGHAMTON-JOHNSON CITY JOINT SEWAGE BOARD
ALL ELIGIBLE EMPLOYEES
2020-104313 (07/22)

Kit created 10/13/2022
Group number: 00581589

Guardian®

Your vision coverage

Option 1: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of VSP's network locations, including one of the largest private practice provider networks, Visionworks and contracted Pearle Vision locations.

Your Vision Plan	**Full Feature**	
Your Network is	VSP Choice Network	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 25	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $39
Single Vision Lenses	$0	Amount over $23
Lined Bifocal Lenses	$0	Amount over $37
Lined Trifocal Lenses	$0	Amount over $49
Lenticular Lenses	$0	Amount over $64
Frames	80% of amount over $130[1]	Amount over $46
Costco, Walmart and Sam's Club Frame Allowance	Amount over $0	
Contact Lenses *(Elective)*	Amount over $130	Amount over $100
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	Up to $60	Not Applicable
Cosmetic Extras	Avg. 20-25% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price**	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	
Frames	Every two calendar years‡‡‡	
Network discounts *(glasses and contact lens professional service)*	Limitless within 12 months of exam.	
Dependent Age Limits	26	
To Find a Provider:	Register at VSP.com to find a participating provider.	

VSP

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- ** For the discount to apply your purchase must be made within 12 months of the eye exam.
- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.
- [1]Extra $20 on select brands
- Members can use their in network benefits on line at Eyeconic.com.

Guardian®

Your vision coverage

- ‡‡‡.*The VSP system considers contact lenses to be the equivalent of a full pair of eyeglasses (lenses and frames) so while the member can obtain contact lenses one year and standard eyeglass lenses the next year, the frames benefit would not be available until 24 months or two calendar years, depending on the plan design, after the date the member obtained the contact lenses.*
- In Network Routine Retinal Screening Covered after no more than a $39 copay.

EXCLUSIONS AND LIMITATIONS

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-VSN-96-VIS et al.

Laser Correction Surgery:

Discounts on average of 10-20% off usual and customary charge or 5% off promotional price for vision laser Surgery. Members out-of-pocket costs are limited to $1,800 per eye for LASIK or $1,500 per eye for PRK or $2300 per eye for Custom LASIK, Custom PRK, or Bladeless LASIK.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

IMPORTANT "COORDINATION OF BENEFITS" INFORMATION - Participants obtaining Vision Care, should first submit their claims through the Binghamton-Johnson City Joint Sewage Board's Guardian Vision Group Plan, on a "primary" basis. After the Participant's claim has been processed by Guardian, any balance remaining may be submitted to Aetna under the Vision Benefits on a "secondary" basis (see, "VISION SERVICES" grouping at the bottom of page M-4 of the Aetna Medicare [P01] ESA-PPO benefit summary).

Guardian®

Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

Important information

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.
Visit **https://www.guardiananytime.com/notice48** to read more.

No Cost Language Services

Guardian provides language assistance in multiple languages for members who have limited English proficiency.
Visit **https://www.guardiananytime.com/notice46** to read more.

Vision insurance

Guardian's HIPAA Notice of Privacy Practices

The notice describes how health information about you may be used and disclosed and how you can access this information.
Visit **https://www.guardiananytime.com/notice50** to read more.

Guardian

Group Insurance Enrollment/Change Form

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: BINGHAMTON-JOHNSON CITY JOINT SEWAGE BOARD	Group Plan Number: 00581589	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Add Employee Dependents ❑ Drop/Refuse Coverage ❑ Information Change

Class:_____ Division:_____ Subtotal Code:_____ (Please obtain this from your Employer)

About You:

First, MI, Last Name:

Employer Provided Identification:

_____

Social Security Number or Taxpayer Identification Number (TIN)

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Your Social Security Number of TIN must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.

Address	City	State	Zip

Gender: ❑ M ❑ F Date of Birth (mm-dd-yy): ____ - ____ - ____

Phone (indicate primary): ❑ Home (____) ____ - ____
❑ Work (____) ____ - ____
❑ Mobile (____) ____ - ____

Email Address (indicate primary) ❑ Home _____ ❑ Work _____

Are you married or do you have a partner? ❑ Yes ❑ No Date of marriage/union:____-____-_____
Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child: ____-____-_____

About Your Job: Job Title:

Work Status:
❑ Active ❑ Retired ❑ Cobra/State Continuation
Hours worked per week: _____

Date of full time hire: _____ - _____ - _____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (wherever the term "Spouse" appears on this form, it also includes "Partner"). Address/City/State/Zip: Phone: ( ) -		Gender ❑ M ❑ F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

CEF2021-NY

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Oct 18, 2022

V-7

Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

Drop Coverage:

❑ Drop Employee ❑ Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

❑ Vision ❑ Employee ❑ Spouse ❑ Child(ren)

Loss Of Other Coverage:

I and/or my dependents were previously covered under Loss of coverage was due to:

❑ Termination of Employment: _____-_____-_____

❑ Divorce/Separation _____-_____-_____

❑ Death of Spouse _____-_____-_____

❑ Termination/Expiration of Coverage _____-_____-_____

Coverage Lost ❑ Vision

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

Vision Coverage: You must be enrolled to cover your dependents. Check only one box.

	Employee Only	Employee & Spouse	Employee & Dependent/Child(ren)	Employee, Spouse & Dependent/Child(ren)
Full Feature	❑	❑	❑	❑

❑ I do not want this Vision coverage because (Check all that apply):

- ❑ I am covered under another Vision plan
- ❑ My spouse is covered under another Vision plan
- ❑ My dependents are covered under another Vision plan

Signature

- I understand that my dependents cannot be enrolled for a coverage if I am not enrolled for that coverage.
- An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.
- I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.

Guardian Group Plan Number: 00581589 Please print employee name:

- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I agree that my employer or my employer's designated administrator may deduct premiums from my pay apply premiums to my credit card or debit card add premiums to my dues withdraw premiums from my designated bank account, apply premiums to my credit or debit card if they are required for the coverage I have chosen.
- By my signature below, I affirmatively consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days prior written notice
- By my signature below, I affirmatively consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- **I state that the information provided above is true and correct to the best of my knowledge and belief.**

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ DATE _____

Enrollment Kit 00581589, 0001, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

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

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits subject to the conditions/provisions of the policy.

Oregon: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material thereto, may be committing a fraudulent act, and may be subject to civil penalties or dental of insurance benefits.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

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

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.