Health Benefits Program Notice
for Active Joint Sewage Board Employees (C.S.E.A. and Hourly)
effective January 1, 2024

In accordance with the CSEA Contract that expires on 12/31/2025:

> Employees shall pay 18.0% of health insurance program costs during 2024. (This provision continues until amended or changed under a successor CSEA Contract).

> 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 above-listed items are negotiable and consistent with the terms of the ratified 2021-2025 CSEA Contract.

The costs and deductions for the plans and included programs/services will change January 1, 2024, to those shown below. These plans are not available to Medicare-eligible spouses or dependents. If you have a Medicare-eligible spouse or dependent, please request the Medicare Addendum Notice from the Secretary in the Plant Office (Michele).

program including EXCELLUS - BLUE CROSS / BLUE SHIELD - SimplyBlue Plus Bronze 4

	INDIVIDUAL EMPLOYEE	EMPLOYEE plus CHILD[REN]
Total Monthly Cost	**$678.09**	**$1,152.73**
82.0% paid by Employer	**$556.04**	**$945.24**
18.0% paid by Employee	**$122.05**	**$207.49**
Bi-weekly deduction	**$56.34**	**$95.77**

	EMPLOYEE plus SPOUSE	FAMILY
Total Monthly Cost	**$1,356.15**	**$1,932.54**
82.0% paid by Employer	**$1,112.04**	**$1,584.69**
18.0% paid by Employee	**$244.11**	**$347.85**
Bi-weekly deduction	**$112.66**	**$160.55**

Your bi-weekly health insurance program premium will be deducted 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.

Pursuant to Article 11.2 Medical Insurance Buy-Out Benefit: Employees shall have the option to choose not to receive health insurance coverage so long as the employee provides proof of alternate insurance coverage annually. Any employee choosing this option shall receive up to $5,000 per year. Partial payment of the Buy-Out will be made bi-weekly for each pay period the employee is eligible for the Buy-Out. For 2024, the bi-weekly amount is: **$192.31** per pay period.

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***>

DRAFT

What's Included?

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When you sign-up for any of the health insurance plan options, or the optional Medical Insurance Buy-Out Benefit, the programs and benefits shown under the corresponding heading are also included:

program including EXCELLUS – BLUE CROSS / BLUE SHIELD – SimplyBlue Plus Bronze 4

- ► separately-administered (*i.e., not an insured Excellus service*) pre-tax Premium Payment Program for deduction of employee's health insurance program premium from bi-weekly pay (*unless waived as provided on the front of this notice*)

- ► Excellus SimplyBlue Plus Bronze 4 Hospital, Medical and Major Medical group health insurance plans and associated Prescription Drug insurance plan (***see pages B-1 through B-6 and Rx-1 through Rx-10, together with the Application Form [including Dental]: APP Page 1 through APP Page 4, attached***)
  ******* Please see the important "Coordination of Benefits" information on page B-4 *******

- ► separately-administered (*non-insured*) Employer-Funded Health Reimbursement Account (HRA) providing – after first $600.00 per year in covered expenses has been incurred by a patient – up to $7,400.00 per Individual per year (for 2024), but not more than $14,800.00 per year (for 2024) for all persons covered under a multi-person enrollment (i.e., Employee plus Child[ren], Employee plus Spouse, or Family)

- ► an insured Dental Expense Program (***see pages D-1 and D-2, near the back of this notice packet, together with the Application Form [including SimplyBlue Plus Bronze 4]: APP Page 1 through APP Page 4, attached***)

- ► an insured Vision Expense Program (***see pages V-1 through V-10, attached near the back of this notice packet***)
  ******* Please see the important "Coordination of Benefits" information applicable to Vision Benefits (including eyeglasses) inside the green box on page V-5 *******

- ► eligibility to enroll in separately-administered (*i.e., not an insured Excellus service*) pre-tax Flexible Spending Program for payment of qualifying unreimbursed medical expenses and/or qualifying dependent care expenses (note: ***completion of a separate enrollment form is required - see pages X-1 and X-2, 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 (*as of January 2024*)

- ► ability to obtain Claims Assistance/Resolution Services from Haylor, Freyer & Coon, Inc.

Optional Medical Insurance Buy-Out Benefit

(requires completion of a Waiver Form [*see pages W-1 and W-2, attached at the back of this notice packet*])

- ► eligibility to enroll in separately-administered pre-tax Flexible Spending Program for payment of qualifying unreimbursed medical expenses and/or qualifying dependent care expenses (note: ***completion of a separate enrollment form is required - see pages X-1 and X-2, attached near the back of this notice packet***)

- ► cash payment added to bi-weekly pay (subject to all applicable taxes)

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

Excellus BCBS: SimplyBlue Plus Bronze 4

A nonprofit independent licensee of the BlueCross BlueShield Association

Coverage Period: 01/01/2024 - 12/31/2024

Coverage for: Family | **Plan Type:** PPO

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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or visit Our website at www.excellusbcbs.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $8,000 Individual/ $16,000 Family; Out-of-Network: $10,000 Individual/ $20,000 Family *** - see note on page B-4	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $8,000 Individual/$16,000 Family; Out-of-Network: $10,000 Individual/ $20,000 Family *** - see note on page B-4	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Costs for premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	No Charge	None
	Specialist visit	No Charge	No Charge	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 Exam per 1 CalendarYear
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: No Charge Blood Work: No Charge	X-Ray: No Charge Blood Work: No Charge	None
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.excellusbcbs.com/rxlist	Tier 1 (Generic drugs)	No Charge	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription Preauthorization required. If you don't get a preauthorization, you must pay the entire cost and submit a claim to us for reimbursement.
	Tier 2 (Preferred brand drugs)	No Charge	Not Covered	
	Tier 3 (Non-preferred brand drugs)	No Charge	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	
If you need immediate medical attention	Emergency room care	No Charge	No Charge	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	No Charge	No Charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	No Charge	None
	Inpatient services	No Charge	No Charge	
If you are pregnant	Office visits	No Charge	No Charge	Cost sharing does not apply for preventive services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No Charge	No Charge	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery facility services	No Charge	No Charge	None
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	40 Visits per contract year limit
	Rehabilitation services	No Charge	No Charge	60 Visits per 1 CalendarYear limit
	Habilitation services	No Charge	No Charge	60 Visits per 1 CalendarYear limit
	Skilled nursing care	No Charge	No Charge	200 Days per contract year limit
	Durable medical equipment	No Charge	No Charge	None
	Hospice services	No Charge	No Charge	210 Days per contract year limit Family bereavement counseling limited to 5 Visits per contract year
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	1 Exam per contract year
	Children's glasses	No Charge	No Charge	1 Purchase per contract year
	Children's dental check-up	No Charge	No Charge	None

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

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

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

••••••••••••••••••••••••••••••••••*To see examples of how this plan might cover costs for a sample medical situation, please see the next page.* ••••••••••••••••••••••••••••••••••

***** - under the Joint Sewage Board's Employer-Funded Health Reimbursement Account (HRA) -- *after the first $600.00 per year in covered expenses has been incurred by a patient* -- up to $7,400.00 per Individual per year (for 2024) will be paid by the HRA, but not more than $14,800.00 per year (for 2024) for all persons covered under the same multi-person enrollment (i.e., Employee plus Child[ren], Employee plus Spouse, or Family).**

IMPORTANT "COORDINATION OF BENEFITS" INFORMATION - (*may save Participants unnecessary out-of-pocket outlays*)

Participants are notified that the unique coordinated Health Reimbursement Account (HRA) structure of the Binghamton-Johnson City Joint Sewage Board Health Benefits Program is designed to result in cost savings, on an overall basis. **Generally, Health Care Providers are not aware of our Program's structure.**

PARTICIPANTS ARE ADVISED TO **WAIT** UNTIL FULL PROCESSING OF THEIR MEDICAL CLAIMS IS COMPLETED, AND AFTER A FINAL **EXPLANATION OF BENEFITS** STATEMENT IS RECEIVED, **BEFORE** MAKING PAYMENT OF BALANCES CLAIMED DUE BY THEIR PROVIDERS AT THE TIME OF SERVICE.

Further, **no Co-Pay** (*charged under some other types of insurance plans*) is required to be paid by the Patient at the time of service for any of the services outlined on pages B-1 through B-4, above. A **Coinsurance**, or **Cost Share**, may be payable for certain services, where listed on pages B-1 through B-4, above.

Under the Plan Design, an Individual-Enrollment Participant is subject to making payment of the first **$600.00** in charges as a Plan-Cost-Share "**Deductible**" against the first services received during 2024. A Participant enrolled as a part of a multi-person enrollment (for example, Family, Employee + Spouse, or Employee + Child[ren]) is subject to making payment of the first **$1,200.00** in charges as a Plan-Cost-Share "**Deductible**" toward the first services received in a given calendar year *until the entire multi-person enrollment group, collectively, has paid its $1,200.00 "group" Plan-Cost-Share "Deductible"*.

After the above Plan-Cost-Share "**Deductible"** is paid in 2024, the HRA funded by the Joint Sewage Board makes payment of up to the next $7,400.00 (Individual) or $14,800.00 (multi-person enrollment) in medical care costs toward the Excellus SimplyBlue Plus Bronze 4 Deductible and Out-of-Pocket-Maximum stated on page B-1. If **In-Network Providers** are used, no further costs are payable by the Patient for the types of services outlined on pages B-1 through B-4, above. (If Out-of-Network Providers are used, an Individual may become liable for up to $2,000.00 in costs after the HRA is exhausted in a given year, and a member of a multi-person enrollment group may become liable for up to $4,000.00 in costs after the HRA is exhausted in 2024). The HRA funded by the Joint Sewage Board is administered by an organization other than Excellus (and, for this reason, a Provider cannot find out *from Excellus* how much would be paid by the HRA for a given service). Additionally, Employees who have elected to establish **Flexible Spending Accounts** (FSAs) may have FSA monies available to pay remaining unreimbursed medical care costs.

Given the sequence of payments by the funding sources outlined above, Participants may find that they are better-off to **wait** until all of the payment processing steps applicable to their particular health care services have been completed, and a final **Explanation of Benefits** statement is received, **before** making payment of balances claimed due by their Providers at the time of service.

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

About these Coverage Examples:

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

Peg is Having a Baby

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

/ *** - see note on page B-4

The plan's overall deductible	$8,000
Coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$12,690**

In this example, Peg would pay:

Cost Sharing	
Deductibles *** - see note on page B-4	$8,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,060**

Managing Joe's type 2 Diabetes

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

/ *** - see note on page B-4

The plan's overall deductible	$8,000
Coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles *** - see note on page B-4	$5,420
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,440**

Mia's Simple Fracture

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

/ *** - see note on page B-4

The plan's overall deductible	$8,000
Coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$2,800**

In this example, Mia would pay (This condition is not covered, so patient pays 100%):

Cost Sharing	
Deductibles *** - see note on page B-4	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Notice of Nondiscrimination

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

The Health Plan:

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

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

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

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

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

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

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

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

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

Check Desired Action
☐ Add ☐ Cancel ☐ Change

_____
Employer Name

Association/Chamber Name (if applicable)

_____
Group Administrator's Signature (required)

Date

_____
Employee's ID Number

_____
Department Number

Medical Information

_____
Medical Group Number (8 digits)

_____ _____
Medical Subgroup Medical Class

_____ . _____ . _____
Medical Effective Date

Who do you need Medical coverage for?
☐Self Only ☐Family ☐Self & Child(ren)
☐Self & Spouse, or Self & Domestic Partner

Medical Plan Selection

☒ **SimplyBlue Plus Bronze 4 (TCI0)**
☐
☐
☐

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 Excellus under the SimplyBlue Plus Bronze 4 coverage which, as provided on page **B-3**, affords the following Vision Benefits on a "secondary" basis:

Bronze 4 Vision Benefits	In-Network	Out-of-Network
Adult Routine Vision Exam	(please refer to the Excellus Plan document)	(please refer to the Excellus Plan document)
Adult Diagnostic Vision	(please refer to the Excellus Plan document)	(please refer to the Excellus Plan document)
Adult Eyewear	(please refer to the Excellus Plan document)	(please refer to the Excellus Plan document)
Pediatric Routine Vision Exam	Covered at 100% for one routine exam every year, subject to the deductible	Covered at 100% for one routine exam every year, subject to the deductible
Pediatric Eyewear	Covered at 100%, subject to the deductible for one purchase per plan year	Covered at 100%, subject to the deductible for one purchase per plan year

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.

Flexible Spending Account Enrollment Form

Employer Name: _____

Participant Name (First, MI, Last): _____

Social Security Number: _____ - _____ - _____ Phone Number (_____) _____

Address: _____

City, ST, ZIP: _____

Date of Birth: _____/_____/_____ Date of Hire: _____/_____/_____

Email Address: _____

FSA Benefit Election	Per Pay Period Amount	Total Annual Amount	# Pays Per Year
☐ Health Care Election—Standard	$	$	
☐ Health Care Election—Limited	$	$	
☐ Dependent Care Election	$	$	

Carrier Information.

Check the boxes if you are enrolled in any of these benefits through your employer.❑ Medical; ❑ Dental; ❑ Vision; ❑ Rx

Automated Claims Transfer: If you are eligible for ACT (check with your Employer), certain expenses submitted through your insurance provider may automatically be reimbursed to you, unless you or any of your dependents have Coordination of Benefits (COB) with other Plans. This feature is not applicable to Health Spending Card holders.

☐ I do not want ACT or I have COB and am not eligible for ACT.

Spouse/Dependent Information (Attach additional pages if necessary)

☐ I do not have a spouse or dependents

Name	Social Security Number	Date of Birth	Gender	Relationship

Enroll in Direct Deposit

To sign up for direct deposit, please log into the LBS consumer portal at **https://www.lifetimebenefitsolutions.com/start**. Your personalized consumer portal will be available to access on or after your effective date. Upon entering your bank account information, there will be a verification process to complete activation of your direct deposit. Your direct deposit will not be active until the micro-deposit is verified.

Participant Authorization—Return signed form to your Employer.

By signing below I agree to participate in my employer's pre-tax program and certify that I understand and will comply with the regulations governing such Plan. I understand the basic provisions provided on page 2 of this form are guidelines only and that my Plan's Summary Plan Descriptions prevails.

Participant Signature: _____ Date: _____

To Be Completed by the Employer

❑ New Hire ❑ Open Enrollment Effective Date: _____

First Payroll Deduction Date: _____

- Notify Payroll of deduction amount and date
- Keep copy of Enrollment Form for your records
- Forward copy of Enrollment Form or provide data on a file to Lifetime Benefit Solutions

This Plan has employer funded money: ❑ Yes ❑ No. If Yes,

ER Money:	Payroll Based?	Annual Amount
❑ Health Care	❑ Yes ❑ No	$
❑ Dependent Care	❑ Yes ❑ No	$

Flexible Spending Account Enrollment Form

Direct Deposit:

Direct Deposit sends claim reimbursement payments directly to your personal bank account. Direct deposit notification statements will be emailed to you with the details of the reimbursement. If you provide incorrect information and corrective transactions are required, your account may be charged a $25 processing fee. Direct deposit transactions are not subject to the typically imposed $30 check minimum.

Things to Consider Upon Enrollment:

- Your FSA account refers to the combined health care and dependent care components.
- By enrolling in the FSA program, you agree to have your compensation reduced by the amount elected.
- Your election applies to this Plan year only. To continue in the Plan, you must re-enroll each year.
- Annual health care elections are available for reimbursement in full on the first day of the Plan year.
- Dependent care elections are available for reimbursement based on current balance.
- FSA accounts are tracked separately and cannot be combined. These elections are in addition to any premiums you pay on a pre-tax basis for employer sponsored health insurance.
- The dependent care account pays for daycare services needed for a qualifying dependent while you work. A qualifying dependent is a child under age 13 who is claimed as a dependent on your federal income tax return (special rules apply for divorced parents), a disabled spouse, and any other dependent on your tax return who resides in your home and is physically or mentally disabled.
- You may file claims for reimbursement from your FSA accounts for qualified expenses incurred during the Plan year and after becoming a participant. Depending on the provisions in your Plan, some or all of the funds remaining in your FSA account after the end of the Plan's run-out period may be forfeited.
- You will pay the Employer for any tax liability or penalties it incurs if you are reimbursed for an expense that is not a qualified expense, unless you repay the amount or off-set that amount with additional eligible claims within the same Plan year.
- You cannot change the amount of your FSA contributions or pre-tax health insurance premiums, unless you have a qualifying "life change" event as defined in the Plan and satisfy any other conditions for changes contained in the Plan and tax law.
- Your FSA contributions will terminate when your employment terminates. You must check with your Employer to determine if you can elect to continue your health care contributions on an after-tax basis, as allowed under COBRA.
- Your employer may change the amount of your FSA elections if necessary to satisfy tax law requirements.
- You understand that you must provide acceptable documentation for every claim you submit, including Health Spending Card purchases upon request.
- You will keep copies of all documents submitted to Lifetime Benefit Solutions for your own personal records; Lifetime Benefit Solutions is not responsible for retaining copies of your receipts beyond the current Plan year.
- Flexible Spending Accounts and Health Reimbursement Accounts are subject to Federal Law which generally supersedes state law.
- Any person who qualifies as your dependent for federal income tax purposes, or your child even if he or she does not qualify as your dependent for federal income tax purposes but only through the end of the calendar year in which the child reaches age 26.

Excellus 165 Court Street
Rochester, NY 14647

(complete this form only if electing the Buy-Out Benefit)

ExcellusBCBS.com

Waiver of Group Coverage

Company Name: _____

Employee Name: _____ Date of Birth: _____

Health Plan (Product) Effective Date: _____ Average number of hours working weekly _____

I understand that I am eligible to participate in my employer's group health insurance coverage and that my employer is contributing the following amount to the health plan(s) premium:

Product Name: _____

Monthly Contribution Dollar Amount:

Single $_____ Family $_____ Other (amount & tier) $_____ $_____

Product Name: _____

Monthly Contribution Dollar Amount:

Single $_____ Family $_____ Other (amount & tier) $_____ $_____

Please Check All That Apply:

☐ I waive my employer's group **health** insurance coverage for myself and my dependents (if any).

☐ I waive my employer's group **dental** insurance coverage for myself and my dependents (if any).

Reason for Waiving Coverage - Please Check One:

☐ Covered through spouse's employer ☐ Covered through a parent's employer

☐ Under 65 Retiree covered by previous employer's insurance program

☐ Other Please specify: _____

Please Read and Sign Below:

In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. For example,

- Within 30 days of involuntarily loss of other group coverage

- At the time of my employer's open enrollment.

Signature: The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete.

Employee Signature: _____ Date:_____

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