welcome

healthy changes

everything:

BlueCross BlueShield
of Western New York
BlueCross BlueShield of Western New York is more than just a plan. We partner with you to offer your employees high-quality, affordable coverage options. We back these plans with the most extensive network of doctors and hospitals in the world. And, our wellness programs and resources encourage healthy lifestyle changes.

We serve employer groups with locations in the following counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming.
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healthy changes everything®
customer service

Your contacts
• Your account executive or sales consultant is ready with answers, or
• For eligibility questions, call our Billing and Enrollment Department at 1-800-430-7984.

Your employees’ contact
• Chat with a customer service representative at bcbswny.com, Monday through Friday, 8 a.m. to 7 p.m., or
• Call us at 1-800-544-2583, Monday through Friday, 8 a.m. to 7 p.m.

TTY line
TTY users should call Customer Service at 1-716-887-8426.

Medicare Advantage service
For information about our Medicare Advantage plans, you or your employees can call us at 1-800-329-2792 (TDD line users should call 1-877-834-6918).

Anti-fraud hotline
To report suspected insurance fraud in confidence, call 1-800-333-8451.

Mental health and substance abuse
For help obtaining treatment, call 1-877-837-0814.

Pharmacy
For pharmacy-related questions, call Express Scripts® at 1-800-939-3751, 24 hours a day, 7 days a week.

Health Advocate
For patient advocacy services, call 1-800-359-5465, or visit healthadvocate.com.
group structure

The BlueCross BlueShield group structure is divided into the following ID number categories:

<table>
<thead>
<tr>
<th>Parent group</th>
<th>9-digit identifier for your parent company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>8-digit identifier for your group</td>
</tr>
<tr>
<td>Subgroup</td>
<td>4-digit identifier used to separate sets of employees or locations</td>
</tr>
<tr>
<td>Class</td>
<td>4-digit identifier for the plan design</td>
</tr>
</tbody>
</table>

Example:
ABC Company is headquartered in the Western New York service area and acquires XYZ Inc. ABC Company has two locations, ABC North and ABC South, and offers a health maintenance organization (HMO) plan to all employees. XYZ Inc. has one location and offers a preferred provider organization (PPO) plan to all employees.

A possible group structure is as follows:

<table>
<thead>
<tr>
<th>Parent group ID</th>
<th>Group ID</th>
<th>Group name</th>
<th>Subgroup ID</th>
<th>Subgroup name</th>
<th>Class ID</th>
<th>Class name</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456780</td>
<td>12345678</td>
<td>ABC Company</td>
<td>0001</td>
<td>ABC North</td>
<td>0001</td>
<td>HMO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0002</td>
<td>ABC South</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1234569</td>
<td>12345679</td>
<td>XYZ Inc.</td>
<td>0001</td>
<td>XYZ Inc.</td>
<td>0T01</td>
<td>PPO</td>
</tr>
</tbody>
</table>
eligibility requirements

BlueCross BlueShield offers group plans to employers with two or more eligible employees. When a business has multiple locations in and outside of our service area, employees will be combined to determine the size of the group.

**General guideline**
Any requests for eligibility changes should be received within 30 days of the event date. This includes new hires, open enrollment - benefit changes; eligibility changes such as adding or terming a dependent due to birth, death, marriage or loss of coverage; and terminations for left employment, layoff, downsizing, or firing (such as gross misconduct).

**New employees**
Enrollment applications must be submitted within thirty (30) days of the eligibility date, which is determined by your probationary (waiting) period. After thirty (30) days, employees must wait for the open enrollment period to submit their applications.

**Eligible dependents**
When adding or terming a dependent to an existing contract, eligibility changes received more than 30 days after the requested effective date, will be effective the first day of the next month.

**For example:** If the requested effective date for a new dependent is January 1, 2013, but we do not receive the information until March 22, 2013, the effective date will be April 1, 2013.

Health plans that provide dependent coverage are required by law to make this coverage available until age 26, regardless of group size or funding arrangement.

Dependent coverage is available to young adults up to age 26 even if they:
- No longer live with their parents
- Are not listed as a dependent on a parent’s tax return
- Are no longer a student
- Are married (spouses and children of the young adult do not qualify)

**Grandfathered plans:** Grandfathered health plans are not required to make this age 26 coverage available to their employees’ dependents until January 1, 2014 (per Health Care Reform law) if they are eligible for coverage aside from their parent’s plan. If and when you do offer the coverage, confirmation of the young adult’s eligibility for their own employer-sponsored coverage is your responsibility.
eligibility requirements (cont.)

New York’s Age 29 Law
Revisions to New York State insurance laws in 2009 provide the following coverage opportunities for young adults who are 29 years of age or younger, when they meet specific criteria.

• “Young Adult Option” – allows eligible, unmarried young adult children who exceed the age for dependent coverage under their parent’s group health insurance policy to purchase individual coverage through their parent’s group policy, regardless of their financial dependence.

• “Make Available Option” – is available when the group or contract holder purchases a rider to extend dependent coverage through age 29 under family coverage. This allows eligible, unmarried young adult children to remain a dependent on their parent’s policy through age 29, regardless of their financial dependence.

For more information on either option, please visit:
dfs.ny.gov/insurance/health/S6030_Age29.htm

Medicare eligibility
You must submit a Medicare Certification form within ninety (90) days of a member’s Medicare effective date. This applies to anyone on Medicare regardless of age, including disabled individuals. Please submit this information on an enrollment application with a copy of their Medicare card.

Employees who do not enroll in Part B may incur more out-of-pocket expenses. For more information, visit Medicare.gov.

Eligibility questions
Contact your dedicated account specialist or call our Billing and Enrollment Department at 1-800-430-7984.
enrollment procedures

Open enrollment and anniversary date
During open enrollment, your employees may elect BlueCross BlueShield coverage, change plans, and add or remove dependents.

To allow sufficient time to process enrollment applications and produce ID cards, employee informational meetings should be held four to six weeks prior to the start of the plan year.

Anniversary date
Your contract anniversary date:

- Is determined at the time of your initial enrollment
- Is when rate adjustments may occur
- Applies to all of the BlueCross BlueShield plans you offer
- Is when you can change your probationary and open enrollment periods

Recommended timeline
Although the schedule varies among employers, the following is a recommended timeline to use in accordance with your anniversary date:

<table>
<thead>
<tr>
<th>Days before anniversary</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-90</td>
<td>Select the benefit package for the renewal</td>
</tr>
<tr>
<td>30-45</td>
<td>Present benefit changes/options to employees</td>
</tr>
<tr>
<td>15-30</td>
<td>Employees choose their coverage</td>
</tr>
<tr>
<td>15</td>
<td>Submit enrollment applications</td>
</tr>
<tr>
<td>1-15</td>
<td>We process applications and mail ID cards to your employees</td>
</tr>
</tbody>
</table>

You need to confirm the eligibility of each enrollee and verify information is correct and complete on all applications. Please ensure the following information is included on all applications:

- Your group ID number
- Subgroup and class numbers
- Hire/rehire or retire dates
- Effective date of coverage
- COBRA effective date
- Your signature and date (electronic or written)

- Date fields should be MM/DD/YYYY
- Reason for enrollment/change
- Employee/subscriber employment status (active, retired, or COBRA)
- Subscriber plan selection
Enrollment procedures (cont.)

**Enrollment options**
Choose the enrollment method that is most convenient for you:

**eEnroll** Contact your sales consultant or account executive to see if we can create an online enrollment site for your group where you can then choose from four different entry methods:

- **Generic** Your employees enter their information and then send it to you for approval and submission.
- **Self** Your employees enter and submit their own information.
- **Initialized** You fill out the group plan information and send it to your employees. They provide their information and send it back to you for approval and submission.
- **New** Completed entirely by you.

You must complete a HIPAA 21 form and an Online Services Agreement form prior to registering online, in order to obtain access to the secure eServices site. Contact your sales consultant or account executive to assist with eServices enrollment.

**Electronic file** We can work with your HIPAA-compliant vendor.

**File transfers** Provide your information to us in Microsoft Excel and we’ll process it.

**Online applications** Download and print paper applications or call for large quantities.

**eServices** at bcbswny.com/employer
With your secure employer site, you can:

- Review your billing and payment history
- Add new subscribers and/or dependents
- Terminate an employee’s coverage
- Update employee information

Some updates will appear immediately and others will update within 24 hours.

**Group benefit changes**
Changes to your benefit, including adding or removing riders, changing tiers, or other contract changes may be made on your anniversary date.

If you would like to change your anniversary date, please contact your account executive or sales consultant.

**Qualifying events**
Qualifying events for contract changes outside of the open enrollment period include:

- Adoption of a child
- Birth
- Death
- Divorce
- Involuntary loss of coverage
- Legal guardianship
- Marriage
- National support notice
Enrollment requests must be received within thirty (30) days of the qualifying event or the change will be processed the first of the month after it is received. If none of these qualifying events apply, the addition or change will be processed at the next open enrollment period.

1 Requires legal documentation
2 Requires proof of loss of coverage

Adding dependents
New dependent enrollment requests must be received within thirty (30) days of the qualifying event or the change will be processed the first of the month after it is received.

Forms for dependent situations
Handicapped Certification Form
For over-aged individuals with disabilities who qualify for dependent coverage.

Affidavit of Domestic Partnership
For individuals who qualify for dependent coverage as a domestic partner when that benefit is provider.

Subscriber level contract changes
Use eServices to make real-time updates to an employee’s status, such as:
- Name or address change
- Adding/removing dependents
- Eligibility or plan changes

Terminations
Subscriber terminations can be submitted through eServices or with a Termination Request Form. Subscriber terminations must be received within thirty (30) days of the termination date.

For example: If the requested termination date is January 31, 2013, but we don’t receive the request until March 22, 2013, the effective date for the termination will be February 22, 2013.

- COBRA (Group) Terminations for Non-Payment
  - We will allow a retro term back 37 days from the date of request.

- COBRA (DBC) Terminations for Non-Payment
  - Our system will identify delinquent DBC subscribers and generate a delinquency letter.
  - You should term as of the paid to date of the contract.

Common causes for termination
- Age limit exceeded: Termination occurs when a dependent exceeds coverage age limits as defined in your BlueCross BlueShield group agreement. It is the employee’s responsibility to notify you within thirty (30) days if a dependent has exceeded the age limit per the policy. You are then obligated to offer COBRA coverage to the dependent.
- Divorce: A spouse’s coverage must be terminated when a divorce occurs. It is the employee’s responsibility to notify his/her employer within thirty (30) days if a dependent is no longer eligible due to divorce. Employers are then obligated to offer COBRA to qualified beneficiaries.
- Termination of employment: The employee decides to leave your organization or you terminate their employment. If you terminate their employment, you are obligated to offer COBRA coverage to any qualified beneficiaries.
billing procedures

Carry forward billing
We use a carry-forward billing process. We recommend that you pay the exact amount billed, regardless of membership changes. Any membership changes that affect the premium amount will be reflected in a future invoice as an adjustment; this includes all prepayments and partial payments.

Bills are typically generated on the 15th of the month prior to the due date. Changes may appear retroactively on a future invoice as an adjustment.

Please use the following chart to determine how mid-month additions, terminations, and subscriber changes—including COBRA—will be billed:

<table>
<thead>
<tr>
<th>Action</th>
<th>Effective date: 1-15th of month</th>
<th>Effective date: 16th - end of the month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adding subscribers</td>
<td>A full month’s premium will be charged</td>
<td>No premium is charged</td>
</tr>
<tr>
<td>Terminating subscribers</td>
<td>No premium is charged</td>
<td>A full month’s premium will be charged</td>
</tr>
<tr>
<td>Subscriber coverage changes</td>
<td>A full month's adjustment is reflected on the bill</td>
<td>No adjustment is reflected on the bill</td>
</tr>
</tbody>
</table>

Payment remittance
Your premium payment is due on or before the due date indicated in the upper right portion of your billing statement. Refer to the attached sample billing statement for a brief explanation of key fields that will appear on your monthly bills.

To ensure your payments are processed on time, please:
- Use the pre-printed envelope provided with your bill
- Include your group ID on your check

If you do not have a pre-printed envelope, please send your payment to:
BlueCross BlueShield of Western New York
PO Box 5132
Buffalo, NY 14240-5132

If you have questions about your bill, please call your account specialist; he or she is listed on your billing statement.
group invoice sample

January 19, 2012

Group ID: 001234567
Subgroup ID: 001
Account Specialist: 00
Invoice ID: 111001

Payment Due Date: 1/1/2012

FINAL BILL

Bill Period From: 01/01/2012 To: 01/31.2012

For Enrollment Inquiries, call 1-800-430-7984 ext XXXX
For Billing Inquiries, call 1-800-430-7984 ext XXXX

<table>
<thead>
<tr>
<th>ID Number</th>
<th>Name</th>
<th>Tier</th>
<th>Cov</th>
<th>Plan</th>
<th>Amount</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Subgroup 0001 Active</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Class 0T12 Traditional Blue PPO 123</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Doe Jane R FMLY M PPO1Y000 1207.06 1207.06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Doe Joseph C SNGL M PPO1Y000 603.53 603.53</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sample Fred E FMLY M PPO1Y000 1207.06 1207.06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regular Charges Totals by Coverage

<table>
<thead>
<tr>
<th>Coverage Category</th>
<th>Subscriber Count</th>
<th>Dependent Count</th>
<th>Total Member Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>M - Medical</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>

Invoice

<table>
<thead>
<tr>
<th>Class 0T12</th>
<th>Totals by Coverage</th>
<th>Regular</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>0</td>
<td>8</td>
<td>83017.65</td>
</tr>
<tr>
<td>Totals by Coverage Adjustment</td>
<td>M</td>
<td>0</td>
<td>3017.65</td>
</tr>
<tr>
<td>Totals by Coverage</td>
<td>M</td>
<td>0</td>
<td>3017.65</td>
</tr>
</tbody>
</table>

Current Balance $3,017.65
Previous Balance $2,017.35

Payments Received

| Payment | 12/31/2011 Chk No 1234 | Total Amount Due $2,017.35 |

Plan Legend

1. Due date of premium payment to guarantee no interruption of service for non-payment of premium.
2. Contact information for billing and enrollment questions.
3. Subgroup IDs are assigned to differentiate multiple billing situations and site locations. Every group is assigned at least one subgroup ID.
4. Class numbers are used to identify employees by classification or benefit level.
5. Tier identifies contract type; Single or Family
6. Identifies type of coverage; medical or dental
7. Amount to be paid in full by the due date (the due date is indicated on the upper right portion of the statement.
8. Plan Legend defines the Plan ID Number and identifies the benefit level the employee has chosen.
group terminations

Involuntary termination
Nonpayment of premium
We are committed to effectively managing accounts for groups and subscribers. The following information clarifies our policy regarding the payment of premiums:

• Payment is due on or before the due date. There’s a 30-day grace period beginning the day after your payment due date.
• If payment is not posted within fifteen (15) days of the due date, a letter will be sent to you advising that your premium payment must post prior to the expiration of the 30-day grace period or your coverage may be terminated.
• If the premium payment is not posted within the 30-day grace period, the coverage will cancel retroactively to the end of the last month for which we received payment.
• If your group is cancelled a second time within a 12-month period due to nonpayment of premium, you may not be eligible for group coverage for a period of twelve (12) months.
• If your group’s coverage is not reinstated within sixty (60) days of the termination date, you will not be eligible for group coverage with us for a period of twelve (12) months.
• If your group is approved for reinstatement of coverage, you will be quoted the dollar amount due to reinstate. This amount will include all past and presently due premiums.

Continuous health care coverage is important to both you and your employees. If you have any questions regarding this policy, please contact our Payment Recovery Department at 1-716-887-8446.

Returned checks
If your group’s check is returned to BlueCross BlueShield due to insufficient funds, it will be handled as a nonpayment of the premium.

Voluntary termination
To terminate your group coverage with us, please submit a written request thirty (30) days prior to the effective date of your termination to your account executive.
coordination of benefits

Coordination of benefits (COB) is the process of sharing liability when a member has coverage with more than one health insurance policy covering similar services. We will make every effort to pursue COB revenue when another carrier is responsible for primary coverage.

**Guidelines for determining primary coverage**

When a member is covered by two or more health insurance policies and a service is received that may be covered in part by either plan, we will coordinate benefit payments with the other carrier.

Our payment will be up to the allowable expense defined as “necessary, reasonable, and customary items of expense.” The other carrier(s) will provide secondary benefits, if necessary, to cover the member’s expenses. This prevents duplicate payment and overpayment.

**Determining primary carriers**

1. The plan that does not have a clause or does not comply with Regulation II NYCRR 52 is primary.
2. The plan that covers the person as an employee, member, or subscriber is primary before a plan that covers the person as a dependent.
3. If two or more plans cover an individual as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   - The plan of the parent with custody of the child is primary
   - The plan of the spouse of the parent with custody is secondary
   - The plan of the parent not having custody of the child is tertiary

   If a court decrees that one of the parents is responsible for the health care expenses of the child, that parent’s plan is primary. This parent must notify the plan in order for services to be covered.

4. When two plans cover the same child as a dependent of both covered parents, the following applies:
   - **Parent’s birthday:** Plan benefits of the parent whose birthday falls earlier in the year are determined before those of the parent whose birthday falls later in the year.
   - **Parents with same birthday:** If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
     - If the other plan does not have the rule described above, but instead has a rule based upon gender of the parent – and if, as a result, the plans do not agree on the order of the benefits, the rule in the other plan will determine the order of benefits.

   **Note:** “Birthday” refers only to month and day in a calendar year, not the year the person was born.

5. Primary coverage as an employee:
   - The benefits of a plan that cover a person as an active employee who is neither laid off nor retired are determined before those of a plan that covers that person as laid off or retired.
   - If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6. If none of the above rules determine the order of benefits:
   - The benefits of the plan covering an employee, member or subscriber the longest are determined before those of the plan covering that person for a shorter time.
traveling or residing outside the service area

BlueCard® and BlueCard® Worldwide Programs
The BlueCard® and BlueCard® Worldwide Programs enable members traveling away from home domestically or living abroad to access to doctors and hospitals throughout the U.S. and nearly 200 other countries and territories. With your coverage, you can find:

- Inpatient, outpatient, and professional services from a network of health care providers
- Medical assistance, including referrals to a doctor or hospital and verbal translations between provider and member

*Note:* Access to types of services is determined by your benefit plan.

Use the Blue National Doctor & Hospital® finder at bcbs.com or call BlueCard Access at 1-800-810-BLUE (2583) to locate a domestic or international Blues plan provider.

Away From Home Care® - Guest Membership*
Members enrolled in HMO or POS managed care products (except high-deductible products) have access to health care across the country when temporarily residing away from home for at least ninety (90) days.

This service is helpful for:

- Students: children attending school outside of New York state
- Families apart: families residing in different service areas
- Long-term travelers: members with long-term work assignments in another location or retirees with dual residences

Away From Home Care is available in most states and the District of Columbia. The steps of the program are outlined below:

1. Your employee must contact us (their home plan) to determine if there is a participating plan or host plan in the area where they will be staying.
2. If there is a host plan, we will mail them an Away From Home Care application.
3. Employees must complete the application and return it to us for processing.
4. The host plan will provide your employee with an ID card and assist him or her in selecting a primary doctor. They will also provide instructions on how to access benefits with their guest membership.

Pharmacy coverage is provided under our plan through our pharmacy benefit manager’s national network. Call Express Scripts® at 1-800-939-3751 to locate participating pharmacies.
Consolidated Omnibus Budget Reconciliation Act of 1985 Federal (COBRA)

Federal
COBRA laws require employers with twenty (20) or more full-time and/or part-time employees to continue offering group health insurance to employees and their dependents upon the occurrence of a qualifying event. Information on COBRA can be found on the United States Department of Labor website.

New York
Employees in groups with less than twenty (20) employees may be eligible for continuation of coverage under the New York State Continuation of Coverage Law (mini COBRA).

Duration
The duration of COBRA coverage available under federal and state law is up to a maximum of thirty-six (36) months. COBRA administration is your responsibility as the group administrator.

Changing COBRA Status
If you need to add or remove an employee from your COBRA coverage, please see the information in Qualifying Events in the Enrollment Procedures section of this guide.

OBRA/TEFRA/DEFRA Federal Regulations

Omnibus Budget Reconciliation Act (OBRA)
Groups with one-hundred (100) or more employees who provide coverage are required to continue group coverage as primary insurance for active employees or their dependents who are eligible for Medicare coverage due to a disability.

When an employee retires from the employer group, that employee or their disabled dependent with OBRA coverage will cease to be eligible for OBRA.

Federal Tax Equity and Fiscal Responsibility Act (TEFRA) and Deficit Reduction Act (DEFRA)
Groups with twenty (20) or more full- or part-time employees are responsible for providing the same coverage to working employees age 65 or older (TEFRA) and their nonworking spouses age 65 or older (DEFRA) because they provide for employees under age 65.
Health Insurance Portability and Accountability Act

What is HIPAA?
The Health Insurance Portability and Accountability Act (HIPAA) was enacted on August 21, 1996 and mandates a number of requirements regarding pre-existing conditions, exclusions, special enrollment, guaranteed renewability, certificates of creditable coverage, and patient privacy.

HIPAA ensures personal health information (PHI) privacy
The Privacy Rule creates national standards to protect the privacy of our members’ medical records and other personal health information. For more information on the Privacy Rule, visit hhs.gov/ocr/privacy.

We keep information confidential
We have always been and continue to be committed to maintaining the confidentiality of our members’ information. We will only release protected information in accordance with state and federal law and the guidelines we established for our organization. Here’s a summary of some of the guidelines we follow to keep information confidential:

• Inclusions in routine notifications of privacy practices
  The Notice of Privacy Practices describes how medical information about members may be used and disclosed and how they can get access to this information. For example:
  - Uses and Disclosures of Protected Health Information (covers treatment, payment, health care operations), or
  - Individual Rights (covers member access, accounting of disclosures, confidential communications).

  A copy of the Notice of Privacy Practices is now included in our initial enrollment package and is available on our website or by calling customer service.

• The right to approve release of information (use of authorizations)
  An authorization is not required for treatment, payment, or health care operations and in other instances as required by law. An authorization is required for the release of information in certain circumstances. For example:
  - When releasing information to someone other than the individual and as otherwise permitted by law or when releasing sensitive information (e.g., HIV/AIDS, alcohol/substance abuse).

• Access to medical records
  We do not generate or modify, nor do we maintain, complete copies of medical records. We receive copies of medical records in order to process claims and perform other routine functions in the normal course of business. If your employees want copies of their medical records, they should contact the doctor or facility considered to be the source of these documents.
Health Insurance Portability and Accountability Act (cont.)

- **Protection of oral, written, and electronic information across the organization**
  Corporate information assets in oral, written, and electronic form are protected by establishing and enforcing corporate security and privacy policies and procedures; implementing security and privacy awareness training for all workforce members; and deploying the appropriate physical, administrative, and technical security mechanisms.

- **Information for employers**
  Protected health information will not be released to employers unless the member has authorized the release and/or the proper agreements are in place as permitted by law.

  When information is released to you as the employer, it is released with certain restrictions so confidentiality is maintained. Enrollment/disenrollment and premium quote information is an allowable disclosure under certain law.

**HIPAA specifications**

HIPAA specifies that providing a Certificate of Creditable Coverage is the joint responsibility of you (the employer) and us (the insurer).

We will provide a Certificate of Creditable Coverage each time we process a termination. This will certify the member’s coverage with us only. It then becomes your responsibility to work with other health insurance issuers to coordinate certificates regarding prior coverage under their plans.

A Certificate of Creditable Coverage must be provided when individuals, including dependents:
  - Terminate coverage under their plan
  - End COBRA continuation under their plan

Certificates of Creditable Coverage must also be provided upon request up to twenty-four (24) months after coverage has ended.

Please notify us any time an individual, including a spouse or dependent:
  - Terminates coverage under your plan
  - Begins COBRA continuation under your plan
  - Ends COBRA continuation under your plan

Depending on the number of employees, it may be beneficial for your group health plan to create separate COBRA beneficiaries. We recommend that you request all employees on an annual basis to provide updated information regarding spouses and dependents, including specific dates of divorce and dates on which employees acquire or remove dependents.
Preventive services
To help your employees live healthier lives, we promote preventive health services. These services have $0 copay when received in network with all of our plans. By taking healthy steps with these services, such as immunizations, screenings and routine physical exams, members and their doctors may identify concerns that can be easier to treat when detected early.

Covered preventive services for adults
- Abdominal aortic aneurysm for adults over 50†
- Alcohol misuse screening and counseling
- Aspirin use for men and women of certain ages*
- Blood pressure screening
- Cholesterol screening for adults of certain ages
- Colorectal cancer screening (colonoscopy, sigmoidoscopy, fecal occult exam) for adults over 50†
- Depression screening
- Type 2 diabetes screening
- Diet counseling
- HIV screening
- Immunization vaccines – doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes zoster
  - Human papillomavirus
  - Influenza
  - Measles, mumps, rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, diphtheria, pertussis
  - Varicella
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling
- Tobacco use screening
- Syphilis screening

Covered preventive services for women, including pregnant women
- Anemia screening on a routine basis for pregnant women
- Bacteriuria infection screening for pregnant women
- BRCA counseling about genetic testing
- Breast cancer mammography screenings every 1 to 2 years for women over 40
- Breast cancer chemoprevention counseling
- Breast feeding interventions to support and promote breast feeding
- Cervical cancer screening
- Chlamydia Infection screening
- Folic acid supplements for women who may become pregnant*
- Gonorrhea screening
- Hepatitis B screening
- Osteoporosis screening for women over 60†
- Rh Incompatibility screening for all pregnant women
- Tobacco use screening for all women, and expanded counseling for pregnant tobacco users
- Syphilis screening for all pregnant women

Covered preventive services for children
- Alcohol and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments
Covered preventive services for children (cont.)

- Cervical dysplasia screening for sexually active females
- Congenital hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride chemoprevention supplements for children without fluoride in their water source*
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, weight, and body mass index measurements
- Hematocrit or hemoglobin screening
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening
- Immunization vaccines – doses, recommended ages, and recommended populations vary:
  - Diphtheria, tetanus, pertussis
  - Haemophilus influenza Type B
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus
  - Inactivated poliovirus
  - Influenza
  - Measles, mumps, rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia*
- Lead screening for children at risk of exposure
- Medical history for all children throughout development
- Obesity screening and counseling
- Oral health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually transmitted infection (STI) prevention counseling for adolescents
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening†

Additional services covered in full

- Prostate-specific antigen screening†
- Routine obstetrical/gynecological exam†
- Routine annual physical†
- Routine labs ordered as part of a routine annual physical or routine obstetrical/gynecological exam†

*Prescription required

†For members enrolled in a commercial, direct pay, Healthy NY, or ASO plan, please be aware that some of these services may have a copay or may only be covered in certain age ranges. For more information, please refer to your plan documents or have the member contact our customer service department.

Note: The grandfathering provision of the Patient Protection and Affordable Care Act (PPACA) allows health plans to maintain their benefit plan(s) that was/were in existence on or before March 23, 2010, the date the reform law was signed. Grandfathered health plans are not subject to some of the health care reform provisions that are otherwise mandated.
accessing appropriate care

Helping your employees understand where to get the most appropriate care is one of the best ways to help them control their health care costs.

Primary care doctors
Your employees’ relationship with their primary doctor is important for their long-term health and wellness as their primary doctor has the best understanding of their health history.

The cost for a primary doctor visit will always be less than emergency room or urgent care facility visits. Members should always contact their primary doctor for routine services and non-life-threatening emergencies. The primary doctor can also help the member decide if an emergency room visit is appropriate when the member isn’t sure.

After-hours care
Most health conditions can be treated by primary doctors. They often have extended evening and weekend hours.

Sudden life-threatening ailments
Members experiencing life-threatening pain or illness should go immediately to the nearest emergency room.

Women’s health
Your female employees and female dependents of employees have additional rights to specialized care for women.

Mammography Coverage Information

Screening (preventive) mammograms
A screening mammogram is a routine test that your doctor may recommend on a regular basis (e.g. every year, every other year, etc.) based on your health status. As part of our preventive care benefit, there is no copayment when women:

- 40 years of age or older have an annual screening mammogram; or
- aged 35-39 with no history of breast cancer have one baseline screening during that period of time; or
- of any age with prior history of breast cancer or a first degree relative with a prior history of breast cancer have an annual screening mammogram.

Diagnostic mammograms
When a doctor indicates a medical diagnosis on the bill, it is a diagnostic mammogram. This often occurs when the doctor orders a follow-up mammogram after the screening mammogram because of a possible finding. Diagnostic mammograms are not part of your preventive service benefit so copayment, deductible, or other cost-share requirements for your plan will apply.

A prescription is required
The state of New York requires a prescription for mammography screening. Be sure to obtain a prescription from your doctor for the test before your screening. You will be required to present the prescription at your scheduled appointment time.
accessing appropriate care (cont.)

**Women’s Health and Cancer Rights Act**
The Women’s Health and Cancer Rights Act of 1998 requires health plans that cover mastectomies to also cover breast reconstruction and prostheses. Under this law, we provide coverage to all members for the following services in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas

Your employees and their dependents who require breast reconstruction and prostheses should discuss treatment options with their doctor and refer to their plan materials for coverage information. This coverage is subject to the deductibles, coinsurance, and copayments in their plan.

**The Breastfeeding Mothers’ Bill of Rights**
To promote breastfeeding in New York, the state legislature has enacted the Breastfeeding Mothers’ Bill of Rights, which applies to all maternal health care providers and facilities, effective May 1, 2010. The law is intended to inform new mothers about the benefits of breastfeeding and have maternal health providers encourage and support breastfeeding.

To learn more about this new law and your options, please visit the state’s website at: health.ny.gov/community/pregnancy/breastfeeding
coverage exclusions

Exclusions applicable to most of our health care plan include, but are not limited to, the following:

- Non-covered benefits
- Sex Change (gender-reassignment surgery)
- Artificial means to induce pregnancy (including but not limited to in-vitro fertilization and embryo transfer, except artificial insemination)
- Organ transplant searches, screening, or donation
- Methadone maintenance
- Reversal of elective sterilization
- Hearing aids
- Cosmetic surgery*
- Admission to a hospital before you become covered under this contract
- Government hospital
- No-fault automobile insurance
- Workers’ compensation
- Free care
- Government programs
- Blood (unless part of inpatient hospital care)
- Dental care*
- Military service-related disabilities
- Routine foot care
- Non-covered physical examinations

*Benefit may be provided through a rider to your group contract.

Prescription drug benefits

We partner with Express Scripts® to administer a prescription drug program for you and your employees. Express Scripts® is the largest mail-order pharmacy in the U.S. Express Scripts®’s Rational Med® safety system checks prescriptions for potential drug interaction and other possible medication problems. Your employees can visit bcbswny.com to locate participating local pharmacies.

Express Scripts® offers convenience and savings on prescription drugs with 90-day pricing, home delivery, and generic alternatives. Our half-tablet program helps members save money if they are taking selected antidepressant or cholesterol-lowering medications.

Prescription drug tiers

The amount your employees and their dependents pay for a drug is determined by the prescription copy coverage you chose and where the medication they wish to purchase appears on our medication guide.

Your specific drug plan may cover medications on all three tiers, or you may only have coverage for medications on Tier 1 and Tier 2. Some drug plans also exclude certain drugs or classes of drugs from coverage. Please educate your employees about your specific drug coverage.
medication guide

We develop our medication guide based on recommendations from our Pharmacy and Therapeutics Committee, which includes primary care doctors, specialists, pharmacists, and other health care professionals in our community.

This committee determines which drugs are covered and at what level or tier and this is updated throughout the year. They also oversee guidelines for our drug use review programs, such as prior authorizations, step edits, and quantity limits. Visit bcbswny.com to view the medication guide.

Medication guide symbols and descriptions

Prior authorization

Doctors can submit a prior authorization form to us and we will review the request within three (3) business days, unless additional information is required. Prior authorization helps protect patient safety by monitoring the correct use and dosage of drugs.

- Ensures drugs are used as the FDA intended
- Eliminates off-label use

Step edit

A step edit requires certain medications be tried without success before approval of a non-preferred medication. Step edits help control costs by encouraging members to try comparable preferred drugs with deeper discounts.

Quantity limits

Ensure members receive the appropriate amount of medication.

Specialty pharmacy restriction

Medications must be obtained through a specialty pharmacy.

Mail-order available

Medications may be purchased through Express Scripts® Pharmacy.

Included in our half-tablet program; see description below.

Mail-order prescriptions

To fill a prescription through the Express Scripts® Pharmacy®, members call 1-800-939-3751 anytime, day or night. Express Scripts® will contact his or her doctor to obtain the prescription information.

To transfer an existing prescription to the Express Scripts® Pharmacy for mail order, members can log into Online Services at bcbswny.com and click the Express Scripts® Pharmacy link to go to their personalized, private Express Scripts® page.

After Express Scripts® receives the order, the prescription will be delivered within ten (10) days; free standard shipping is included.
Saving with generics
More than 400 generic medications are available for $10 or less for a 90-day supply through Medco mail order.

Your employees can log into Online Services at bcbswny.com and click the Express Scripts® Pharmacy link to use the My Rx Choices® tool. This feature reviews a member’s current medication(s) and identifies possible generic alternatives with an estimate for potential savings.

Half-tablet program
The half-tablet program is a voluntary program and can cut participants’ prescription costs in half.

1. Members check to see if the medication(s) is eligible and talk to their doctor if it is.
2. The doctor will write a prescription for a higher strength medication with a half-tablet dosage.
3. Members fill their prescription and ask for a tablet splitter (free with the first fill).
4. They split their tablets in half and follow their dosage instructions.

Eligible medications are reviewed by our pharmacy staff to ensure that there is no change in efficacy when medications are split in half. Please contact your account executive for a current list of eligible medications and doses.
Employees can visit bcbswny.com to access information about their plan and our services 24 hours a day, 7 days a week.

Online Services is a secure resource for personalized health care information and services.*

- **eServices**
  - Change PCP
  - Look up claims
  - See referrals/pre-authorizations
  - Order new ID cards

- **Online Care**
  - Secure online consultations with primary care physicians
  - Available to anyone in New York state
  - Doctors can review your health history, answer questions, and prescribe medications

- **Online Tools**
  - **Health Care Advisor**
    - Learn about health, choose a hospital, estimate the cost of care with Treatment Cost Advisor℠
  - Member Guide

- **Express Scripts® Pharmacy**
  - Order prescriptions
  - Check order status
  - Check claims and balances
  - Price a medication
  - Locate a pharmacy

- **My Health**
  - Track personal health and nutritional information
  - Take a health assessment
  - Create wellness plans
  - Consult the Health Library

- **Coverage Advisor**
  - Compare and enroll in health plans

* The personal information that members enter is secure and protected. When they set up an online account, they will be able to view their information. Your employee will also be able to view information for dependents under the age of 18, with limited exceptions that have special restrictions under federal and state law.
online services and tools for members (cont.)

Your employees can interact with us directly online.

**Live Help**
Chat with a customer service representative

**Click & Comment**
Provides members with the opportunity to submit a question or send us comments.

**VirtualVoice**
We care about your employees’ opinions. They are invited to join our online survey panel.

---

**Click with healthy**

**Introducing My Health**

With My Health, you can:

- Set up a personalized page with a snapshot of your health information
- Create a fitness plan that works for you
- Select meal plans
- Analyze your diet and make adjustments when necessary
- Locate wellness workshops
- Make “to do” lists
- Use the tools to track your progress
- Compare your progress with people who have similar goals
online services and tools for members (cont.)

Available forms:

- Affidavit of Domestic Partnership, if eligible
- Claim and Enrollment Forms
- Handicapped Certification Form
- HIPAA Authorization Forms
- Medicare Certification Form

The forms listed above are available online and in the next several pages for your convenience.
your membership card

**FRONT**

Subscriber: 01 John Q. Public
ID: YJP 999999999
Members:
02 Jane Public
04 James Public
Group #: 99999999
RX Group #: HNRXS
RX Bin: 610014
PDS 205
PCP/Specialist copay $20/$20
RX copay $5/$30/$50
No Referral

**BACK**

www.bcbswny.com
For Customer Service
1-800-544-2583
Health Advocate 24-hour line
1-800-359-5465
Mental Health and Chemical Dependency
1-877-837-0814
Pharmacy Member Service
1-800-939-3757
Pharmacy benefits administrator

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<table>
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<tbody>
<tr>
<td>1</td>
<td>Subscriber name and ID number</td>
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<tr>
<td>2</td>
<td>Additional member (Dependents of the subscriber)</td>
</tr>
<tr>
<td>3</td>
<td>Group number, RX group number, and RX number</td>
</tr>
<tr>
<td>4</td>
<td>Product type and cost</td>
</tr>
<tr>
<td>5</td>
<td>Out-of-area coverage (This may vary by plan)</td>
</tr>
<tr>
<td>6</td>
<td>Helpful numbers to call if you need assistance.</td>
</tr>
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</table>

Due to plan variability, not all Member ID cards are identical.
How the claims get paid.

While navigating the health care system can be confusing, our job is to help make it easier so the member can focus on what’s important—getting healthy and staying healthy. Below is a chart that shows how the member’s claim gets paid and how to read the Explanation of Benefits.

An Explanation of Benefits is a summary of provider charges, contract allowances, and patient responsibility amounts.

- **A**: Date(s) service provided.
- **B**: Service the member received.
- **C**: Amount charged for service provided.
- **D**: The negotiated rate between the provider and BlueCross BlueShield for that service.
- **E**: A set dollar amount the member pays for the covered medical care before the benefits start.
- **F**: Your cost-share for services. The amount the members are responsible for paying for certain covered services. Typically a percentage of the contract allowance for the service.
- **G**: Other amounts the member may be responsible for paying, for example a copay.
- **H**: The total amount paid by the health plan.
- **I**: An explanation of a payment or a reason for denial of a claim.

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- **H**: The total amount paid by the health plan.
- **I**: An explanation of a payment or a reason for denial of a claim.

Please Note:
The amounts shown in the sample Explanation of Benefits images are for illustrative purposes only. Actual amounts will vary according to the types of services received and the terms of your member contract.
health and wellness

Health coaching
Because everyone can use some support from time to time, we have health coaches who are available to educate, motivate and support your employees when they are facing health status changes. Programs include:

- Chronic kidney disease
- Home connections palliative care
- Rare conditions
- Right Start pregnancy
- Transplant

Care Management
Managing a chronic illness is easier with a team of people dedicated to supporting the member. We will help your members and their physicians manage the following chronic medical conditions by providing valuable information and treatment options.

- Attention deficit hyperactivity disorder
- Asthma
- Back care
- Cardiac care
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Diabetes

We’ve designed programs that help bring members together with their health care team to manage overall care. If one of your employees or their dependents has a complicated illness, we can help get them the very best care possible.

Health promotion
Our goal is to help people maintain and improve good health – “keep the well well.” This includes our employer-specific programs that address general health risks, such as smoking and obesity, as well as target health concerns that drive up your health care costs.

Onsite health screenings are offered through a third-party vendor and are included to identify employees with health risks and get your employees the support they need. Please ask your account executive about what services are available and appropriate for your group.

Walking Works™
Walking Works™ is an easy-to-implement walking program developed by the BlueCross BlueShield Association to bring physical activity into the work day. Walking Works produces real results, such as weight loss, increased stamina, and reduced blood pressure, stress, and cholesterol.
AFFIDAVIT OF DOMESTIC PARTNERSHIP

STATE OF  )
COUNTY OF  )

The undersigned, being duly sworn, depose and declare as follows:

We are both eighteen years of age or older and unmarried. If either or both of us has been married, we submit evidence of the termination of the marriage.

We are not related by blood in a manner that would bar marriage under the laws of the State of New York.

We are each other’s sole domestic partner, have been so for at least six months prior to the date of this affidavit, and intend to remain so indefinitely. We are in a relationship of mutual support, caring and commitment, and have assumed responsibility for each other’s welfare.

We have been living together on a continuous basis for at least six months prior to the date of this affidavit.

One of us is enrolled in an employer group health insurance program.

Neither of us has been registered as a member of another domestic partnership within the last six (6) months.

I, the enrollee, affirm that I will file a Termination of Domestic Partnership form within 30 days of the date I/my partner no longer meet one or more of the qualifying criteria set forth above.

I, the enrollee, understand that any false or misleading statement made in order to receive benefits for which I do not qualify will subject me to financial responsibility for any benefits paid on behalf of my partner and/or other legal actions appropriate to the prosecution of insurance fraud.

_____________________________   ________________________________
Print Name (Enrollee)      Print Name (Partner)
_____________________________
Address       Address
_____________________________
Signature       Signature

Sworn to before me this Day of , 2

_____________________________
NOTARY PUBLIC

/3660A
To enroll your domestic partner in your employer health insurance benefits program, you must submit a copy of one item of proof that you and your partner have resided together for at least six months. The proof may be one document with both names or two separate documents that show the residence of each partner. The following is a list of some items that can be used to demonstrate proof of residency. You may submit a copy of another document that proves residency began at least six months ago.

☐ Driver’s license
☐ Auto registration
☐ Lease Agreement
☐ Mortgage Agreement
☐ Tax Return
☐ Bank statement
☐ Passport
☐ Insurance benefits statement
☐ Pay check stub
☐ Utility bill
☐ Telephone bill
☐ Joint membership (e.g., church or family association)
☐ Registration as a domestic partnership in the municipalities that have been established such a procedure (e.g., New York City, Rochester, Ithaca)

/3660B
AFFIDAVIT OF FINANCIAL INTERDEPENDENCE

The undersigned, being duly sworn, depose and declare as follows:

We are domestic partners who reside together and are financially interdependent. We submit original documents of two of the following items (at least one of the two items must be from List A) as proof of our financial interdependence.

LIST A
- joint obligation on a loan (including an affidavit by creditor for a personal loan)
- joint ownership of our residence
- joint renters’ or home owner’s insurance policy
- joint responsibility for childcare (e.g., school documents, guardianship)
- designated as beneficiary under the other’s life insurance policy, retirement benefits account or will or executor of each other’s will
- an affidavit by a creditor or other person able to testify to partners’ financial interdependence
- mutually granted durable power of attorney

LIST A (continued)
- designation of one partner as the representative payee for the other’s government benefits
- joint ownership or holding of investments
- joint ownership or lease of our shared residence
- both listed as tenants on the lease of our shared residence
- mutually granted authority to make health care decisions (e.g., health care power of attorney)
- share a household budget for the purpose of receiving government benefits
- I claim my partner as a dependent for federal tax purposes

LIST B
- joint bank account
- joint credit or charge card(s)

LIST B (continued)
- status as authorized signatory on the partner’s bank account, credit cards or charge card
- other proof establishing economic interdependence

NOTE: Proof submitted must show financial interdependence for at least six months.

___________________________________  ___________________________________
Print Name (Enrollee)     Print Name (Partner)

___________________________________  ___________________________________
Address      Address

___________________________________  ___________________________________
Signature      Signature

Sworn to before me this Day of , 2

-------------------------------------
NOTARY PUBLIC

KZ/3660C
**MEDICAL BENEFITS**

**SUBSCRIBER CLAIM FORM**

---

*** MAIL COMPLETED FORM TOGETHER WITH ALL ITEMIZED BILLS TO ADDRESS SHOWN ABOVE. IF CLAIM FORM IS NOT COMPLETE OR IF ANY OF THE ITEMIZED BILLS REQUIRE FURTHER INFORMATION, SUCH MATERIAL MAY BE RETURNED TO YOU WITH ADDITIONAL INSTRUCTIONS. OTHERWISE ALL ITEMIZED BILLS WILL BE RETAINED BY US AND CANNOT BE RETURNED.***

---

**ALL QUESTIONS MUST BE ANSWERED. PLEASE PRINT OR TYPE.**

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<thead>
<tr>
<th>SUBSCRIBER’S LAST NAME</th>
<th>FIRST NAME</th>
<th>INITIAL</th>
<th>BLUECROSS BLUESHIELD ID. NO.</th>
<th>GROUP NUMBER</th>
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ADDRESS-NUMBER AND STREET

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<th>CITY</th>
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PATIENT’S LAST NAME

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<tr>
<th>FIRST NAME</th>
<th>INITIAL</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
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PATIENT’S RELATIONSHIP TO SUBSCRIBER

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<tr>
<th>SELF</th>
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OTHER HEALTH INSURANCE COVERAGE:

DOES PATIENT HAVE ADDITIONAL HEALTH INSURANCE COVERAGE THROUGH EMPLOYER OR OTHER GROUP HEALTH INSURANCE?  

<table>
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<th>YES</th>
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NAME OF OTHER POLICY HOLDER

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<th>POLICY OR IDENTIFICATION NUMBER</th>
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POLICY EFFECTIVE DATE

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<th>TYPE OF COVERAGE</th>
<th>OTHER POLICY HOLDER’S BIRTH DATE</th>
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NAME AND ADDRESS OF OTHER INSURANCE CARRIER

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MEDICARE COVERAGE: IS THE PATIENT ENTITLED TO MEDICARE?  

<table>
<thead>
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PATIENT’S MEDICARE IDENTIFICATION NUMBER

---

MEDICARE PART A (HOSPITAL INSURANCE) EFFECTIVE DATE

MEDICARE PART B (MEDICAL INSURANCE) EFFECTIVE DATE

IS THE PATIENT EMPLOYED?  

<table>
<thead>
<tr>
<th>YES</th>
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IS THE SPOUSE EMPLOYED?  

<table>
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WERE EXPENSES DUE TO AN ACCIDENTAL INJURY?

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TYPE OF ACCIDENT:  

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<th>MOTORCYCLE</th>
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SUBSCRIBER’S SIGNATURE AND ITEMIZATION OF BILLS REQUIRED ON THE OTHER SIDE.
**IMPORTANT NOTICE:**

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 or any other person files an application for insurance containing materially false information concerning a claim for an insurance policy or benefit, shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please remember to attach your itemized bills and sign this claim form.

<table>
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<tr>
<th>CHARGES</th>
<th>DIAGNOSIS OR DESCRIPTION OF ILLNESS</th>
<th>SERVICES OR SUPPLIES</th>
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</tr>
</tbody>
</table>

Enter total charges here

For Blue Cross Blue Shield Office Use Only

For Blue Cross Blue Shield Office Use Only

List below those services or supplies for which you are requesting payment.

In addition, if you have received any payment or rejection notices from Blue Cross Blue Shield or Medicare for those expenses being reported, please attach them.

Note: Canceled checks or cash register tapes are not acceptable.

1. Patient's full name.
2. Amount charged for each service or supply.
3. Date each service or supply was rendered.
4. Description of each service or supply.
5. Diagnosis or nature of illness for each service.
6. Name and address of provider/supplier.
7. Prescription bills must contain prescription number.
8. Name and address of insurance company or other person.

Note: Canceled checks or cash register tapes are not acceptable.

IF YOU HAVE RECEIVED ANY PAYMENT OR REJECTION NOTICES FROM BLUECROSS BLUE SHIELD OR MEDICARE FOR THOSE EXPENSES BEING REPORTED, PLEASE ATTACH THEM WITH THE FOLLOWING INFORMATION INDICATED:

Itemized bills for service or supplies must be attached to this form.
1—Group Employer Information

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

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

<table>
<thead>
<tr>
<th>Group #</th>
<th>Subgroup #</th>
<th>Class #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employer Name

Association/Chamber Name (if applicable)

Group Administrator Signature / Date

2—Subscriber Plan Section

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

<table>
<thead>
<tr>
<th>Plan Number:</th>
<th>Please indicate copay:</th>
<th>PCP $</th>
<th>Specialist $</th>
</tr>
</thead>
<tbody>
<tr>
<td>POS</td>
<td>POS Plus</td>
<td>Dental</td>
<td>HMO</td>
</tr>
<tr>
<td>PPO</td>
<td>Traditional</td>
<td>Vision</td>
<td>EPO</td>
</tr>
</tbody>
</table>

Please choose coverage type:

- Medical
- F
- D
- S

3—Reason for Enrollment/Change

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

- New Hire
- COBRA
- Remove Dependent
- Open Enrollment
- Primary Care Physician
- Loss of Coverage
- Address/Phone Number
- Retirement
- Loss of Coverage
- Add Dependent
- Newborn
- Marriage
- Adoption
- Domestic Partner
- Change in Student Status

4—Subscriber Information

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

<table>
<thead>
<tr>
<th>Subscriber’s Last Name</th>
<th>Subscriber’s First Name</th>
<th>M.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Social Security Number | Date of Birth (MMDDYY) | Telephone Number (include area code) | Gender: |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
</tr>
</tbody>
</table>

Mailing Address

City | State | Zip Code | Marital Status Event Date (MMDDYY) |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E-mail Address

Medicare Eligible

Please indicate reason for Medicare eligibility:

- Age 65+
- Disability
- End Stage Renal Disease

Medicare Number (if applicable)

Form # CN9XAN0002 Rev 5/2010
### 4—Subscriber Information continued

<table>
<thead>
<tr>
<th>Primary Care Physician’s Last Name</th>
<th>Primary Care Physician’s First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
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<tbody>
<tr>
<td></td>
<td>Yes</td>
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</table>

<table>
<thead>
<tr>
<th>Name of Prior Health Care Insurer</th>
<th>Do you have additional group health insurance?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy Identification Number</th>
<th>Policy Effective Date (MMDDYY)</th>
<th>Policy Cancellation Date (MMDDYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### 5—Dependent Information Please provide all information for each person to be covered.

<table>
<thead>
<tr>
<th>Spouse/Domestic Partner’s Last Name</th>
<th>Spouse/Domestic Partner’s First Name</th>
<th>M.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth (MMDDYY)</th>
<th>Male</th>
<th>Are you enrolling as a Domestic Partner?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E-mail Address</th>
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</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Medicare Eligible</th>
<th>Please indicate reason for Medicare eligibility:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 65+</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Number (if applicable)</th>
<th>Part A Effective Date (MMDDYY)</th>
<th>Part B Effective Date (MMDDYY)</th>
<th>Part D Effective Date (MMDDYY)</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Dependent’s Last Name</th>
<th>Dependent’s First Name</th>
<th>M.I.</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth (MMDDYY)</th>
<th>Male</th>
<th>Is your over-age dependent handicapped?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
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<tr>
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</thead>
<tbody>
<tr>
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<td>Age 65+</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
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</tbody>
</table>

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<th>Medicare Number (if applicable)</th>
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</table>

<table>
<thead>
<tr>
<th>Is dependent a full-time student?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
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</table>

<table>
<thead>
<tr>
<th>College/University Name</th>
<th>Expected Graduation Date (MMDDYY)</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Primary Care Physician’s Last Name</th>
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<td>Yes</td>
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<tr>
<th>Name of Prior Health Care Insurer</th>
<th>Do you have additional group health insurance?</th>
</tr>
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<tbody>
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<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy Identification Number</th>
<th>Policy Effective Date (MMDDYY)</th>
<th>Policy Cancellation Date (MMDDYY)</th>
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</table>
### Additional Dependents

**Enrollment Application/Change Form**

#### 5—Dependent Information continued

Please provide all information for each person to be covered.

<table>
<thead>
<tr>
<th>Subscriber’s Last Name</th>
<th>Subscriber’s First Name</th>
<th>M.I.</th>
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<tr>
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<table>
<thead>
<tr>
<th>Dependent’s Last Name</th>
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<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth (MMDDYY)</th>
<th>Male</th>
<th>Is your over-age dependent handicapped?</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>E-mail Address</th>
<th>Medicare Eligible Please indicate reason for Medicare eligibility:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 65+ Disability End Stage Renal Disease</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Number (if applicable)</th>
<th>Part A Effective Date (MMDDYY)</th>
<th>Part B Effective Date (MMDDYY)</th>
<th>Part D Effective Date (MMDDYY)</th>
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<tr>
<th>Is dependent a full-time student?</th>
<th>Yes</th>
<th>No</th>
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<th>College/University Name</th>
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<tr>
<th>Name of Prior Health Care Insurer</th>
<th>Do you have additional group health insurance?</th>
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<th>No</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 5—Dependent Information

**Please provide all information for each person to be covered.**

<table>
<thead>
<tr>
<th>Dependent's Last Name</th>
<th>Dependent's First Name</th>
<th>M.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth (MMDDYY)</th>
<th>Male</th>
<th>Is your over-age dependent handicapped?</th>
<th>Yes</th>
<th>Female</th>
<th>(See instructions for additional information)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E-mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

- Medicare Eligible
- Please indicate reason for Medicare eligibility:
  - Age 65+
  - Disability
  - End Stage Renal Disease

<table>
<thead>
<tr>
<th>Medicare Number (if applicable)</th>
<th>Part A Effective Date (MMDDYY)</th>
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<th>Part D Effective Date (MMDDYY)</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>College/University Name</th>
<th>Expected Graduation Date (MMDDYY)</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</thead>
<tbody>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

- Primary Care Physician Number (see directory)
- Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? Yes No

<table>
<thead>
<tr>
<th>Name of Prior Health Care Insurer</th>
<th>Do you have additional group health insurance?</th>
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<tbody>
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<tbody>
<tr>
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</tbody>
</table>

### HMO/POS Coverage

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and;
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.

### Traditional Coverage

- If you chose Traditional coverage, your contract may include waiting periods for pre-existing conditions. This means we will not pay for any service related to conditions for which you received advice, diagnosis or treatment during the six months immediately preceding the effective date of coverage. Benefits will become available for services related to pre-existing conditions when your contract has been in effect for eleven (11) months.
- We will credit the time you were covered under any other creditable coverage toward the waiting periods for a pre-existing condition on this contract, provided there was no break in coverage greater than 63 days between the termination of the previous creditable coverage and the effective date of your new contract.

### 6—Disclosure / Signature

**Subscriber signature required.**

**Important: Please read and sign below:**

“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 CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

I AUTHORIZE ANY LICENSED DOCTOR, HOSPITAL OR OTHER HEALTH CARE PROVIDER TO PROVIDE MY PLAN WITH ANY INFORMATION REQUESTED CONCERNING MEDICAL SERVICES I OR MEMBERS OF MY FAMILY HAVE RECEIVED, WHICH THE PLAN DETERMINES IS NECESSARY FOR THE OPERATION AND REGULATION OF THE PLAN. THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

☑️ Subscriber Signature ___________________________ Date __________
Unmarried dependent children who became incapable of self-sustaining employment due to either mental illness/developmental disability (as defined by NYS Mental Hygiene Law), mental retardation, or a physical handicap while covered as a dependent child under their parent’s group health benefits (or before reaching age 19 in the absence of such coverage) may be eligible for dependent coverage under their parent’s enrollment regardless of the dependent child’s current age.

In order to determine your child’s eligibility for continued coverage; please provide the information requested on this form. The second page should be completed and certified by your child’s physician. Please return to our plan in the enclosed envelope when completed.

1. Is dependent a full-time student? Yes ____ No ____
   If NO, indicate last grade completed. ___________________
   If special programs have been completed, please indicate type.
   ___________________________________________________________________

2. Name of school ____________________________ Grade ____________

3. Has dependent been employed full or part-time since his/her 19th birthday? Yes ____ No ____
   If YES, give name, address, phone and dates of employment.
   Name ____________________________ Address ____________________________ Phone ____________________________ Dates ____________________________
   ____________________________ ____________________________ ____________________________ ____________________________
   ____________________________ ____________________________ ____________________________ ____________________________
   ____________________________ ____________________________ ____________________________ ____________________________

4. Is dependent receiving Medicare? Yes ____ No ____
   If YES, please provide information from dependent’s Medicare ID card.
   Hospital Insurance Effective Date ____________________________
   Medical Insurance Effective Date ____________________________
   Health Insurance Claim Number ____________________________
   Signature of Subscriber ____________________________ Date ____________________________
Patient’s Name __________________________________________ Date of Birth ________________

Patient’s Diagnosis ________________________________________________________________________

Type of Handicap (Please Check)

  Mental  Developmental  Mental  Physical
  ___ Retardation  ___ Disability  ___ Illness  ___ Handicapped

HISTORY

When did symptoms first appear or accident happen? Date ________________

PRESENT CONDITION

1. At what age level does the patient function? __________________________

2. What I.Q.? __________________

3. Degree of physical impairment? ___ None ___ Mild ___ Severe

4. Degree of psychiatric impairment? ___ None ___ Mild ___ Severe
   a. First date treated by psychiatric care? Date _________________________
   b. Present psychiatrist’s Name __________________ __________________
      Address _________ _____________________________

5. Has handicap existed continuously since patient’s 19th birthday?
   ____ Yes ____ No

6. Is patient capable of self-support? ___ Yes ___ No

7. Is patient capable of attending school? ___ Yes ___ No

8. Is patient:
   ____ Ambulatory  ____ Bed Confined  ____ House or Hospital Confined

9. Can patient use public transportation? ___ Yes ___ No

TREATMENT

1. Date of last visit? __________________________________________________________

2. Current treatment status including mental status and physical exam?
   ___________________________________________________________________________

3. Is patient involved currently in a therapy program? ___ Yes ___ No

4. List hospitalizations, if any:
   Name ___________________________ Dates ___________________________
   Name ___________________________ Dates ___________________________

PROGNOSIS

1. Will the patient make any significant physical or mental progress
   with continued therapies that would improve his/her functional
   status? ____ Yes ____ No

2. Please estimate period patient will remain totally disabled. __________________________

Physician’s Name _____________________________________________________________________________
Address _____________________________________________________________________________
_________________________________________________________________________________
Phone _____________________________________________________________________________
Signature __________________________ Date __________________________
NEW YORK STATE REQUIRED AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV RELATED INFORMATION

Confidential HIV Related Information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.

If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (212) 961-8624 or the New York City Commission of Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

Name of person whose HIV related information will be released:

Name and address of person signing this form (if other than above):

Relationship to person whose HIV information will be released:

Name and address of person who will be given HIV related information:

Reason for release of HIV related information:

Time during which release is authorized:

From:                                                     To:

My questions about this form have been answered. I know that I do not have to allow release of HIV related information and that I can change my mind at any time.

Date (Signature of Patient, Parent, Guardian or Legal Representative)

(Relationship to Patient)

Updated 4-28-03
MENTAL HEALTH, ALCOHOLISM and/or SUBSTANCE ABUSE
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PROTECTED HEALTH INFORMATION (PHI)

CONFIDENTIAL PHI RECORDS SENSITIVE IN NATURE

Certain Federal and State Privacy laws require your express permission before we may discuss/release PHI to your relatives, friends, employer, etc. This authorization is required in order to document your intent and to identify the person(s) who has your permission to contact us on your behalf (“authorized person”) for the reasons mentioned below.

In most instances, your authorization is not required before we may share your PHI with health care providers (e.g. physicians, hospitals, etc.) involved in your treatment or payment for your treatment. This exception is to ensure uninterrupted business operations such as timely submission and processing of your claims. Therefore, it is NOT necessary to name your health care providers as authorized persons.

This authorization is solely for release of PHI related to mental health, alcoholism, and/or substance abuse treatment.

This authorization allows an Authorized Person(s) access to PHI for purposes such as checking claims status, policy benefits, pre-authorization procedures, etc. To authorize the release of records not related to mental health, alcoholism, and/or substance abuse a 2A (Authorization to Use or Disclose PHI) form must be completed.

CONTACT INFORMATION

PLEASE RETURN THIS AUTHORIZATION FORM TO THE APPROPRIATE ADDRESS LISTED BELOW

If you have any questions or need assistance in completing this form, please call the Customer Service telephone number on the back of your identification card or write to:

Privacy Department
PO Box 15013, Albany, NY 12212

Privacy Department
PO Box 80, Buffalo, NY 14240

**ALL SECTIONS ON BOTH SIDES OF THIS AUTHORIZATION MUST BE COMPLETED**

PART 1 – HEALTH PLAN MEMBER (PATIENT) WHOSE PHI WILL BE DISCLOSED

PRINT the following information regarding the specific Health Plan member (patient) to whom this authorization applies:

Member Name: ____________________________ Date of Birth: __________
Address: ________________________________
Member ID#: ______________________________ Telephone: (____ ) _________

PART 2 – ENTITY/ORGANIZATION AUTHORIZED TO MAKE THE DISCLOSURE

PRINT the name of the Health Plan (on the identification card of the member named in Part 1) that is authorized to disclose PHI as specified in this authorization:

Health Plan Name: _______________________

PART 3 – PHI THAT MAY BE DISCLOSED

This authorization permits the Health Plan named in Part 2 to disclose PHI in connection with any claim or appeal for coverage or benefits for (CHECK ALL THAT APPLY):

☐ Mental Health ☐ Alcoholism ☐ Substance Abuse

Disclosure of these records should be for the following dates or date range (if no dates are specified, all records maintained by the Health Plan and related to the issue checked here may be released):_________________________
**PART 4 – AUTHORIZED PERSON(S) TO WHOM THE HEALTH PLAN MAY DISCLOSE PHI**

PRINT the following information regarding the specific individual(s)/organization(s) to whom the Health Plan may disclose the PHI identified in Part 3:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City/State/Zip:</td>
<td>Telephone: (____)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City/State/Zip:</td>
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</tr>
</thead>
<tbody>
<tr>
<td>City/State/Zip:</td>
<td>Telephone: (____)</td>
</tr>
</tbody>
</table>

**PART 5 – AUTHORIZED PERSON(S) LEVEL OF AUTHORITY**

Indicate the level of authority the Authorized Person(s) may have. The first choice is the default selection. If nothing else is marked, the Health Plan will only allow the Authorized Person(s) to discuss the PHI in person or via phone.

The Authorized Person(s) may take the following action(s) in regard to the PHI checked in Part 3:

- [X] Discuss the PHI in person or via phone (he/she is not entitled to copies of the PHI)
- [ ] Receive copies of the PHI (e.g., explanation of benefits, claims history reports, etc.)
- [ ] Any actions the member/patient named in Part 1 is permitted to take

**PART 6 – EXPIRATION DATE AND PREVIOUSLY SUBMITTED AUTHORIZATIONS**

Choose an authorization expiration date below and indicate whether this authorization will replace any already on file with the Health Plan. This authorization must have a specific expiration date/event. ‘Indefinite’, ‘ongoing’, ‘forever’, ‘upon death’, etc. are not considered specific expiration dates/events and cannot be honored.

1. This authorization will expire in (check one): _____ One (1) year _____ Three (3) years _____ Five (5) years from the date received by the Health Plan OR on expiration of the following (e.g. research study): _______________

2. If the information in this authorization is to be added to an authorization previously sent to the Health Plan, the member’s/patient’s initials must be provided here __________. Otherwise all previous authorizations (for the same type of PHI) on file will be voided and the information replaced with the information in this authorization.

If an expiration date is not specified, this authorization will expire one (1) year from the date it is received.

**PART 7 – STATEMENT OF UNDERSTANDING AND SIGNATURE - READ CAREFULLY**

1. Signing this form attests to all information given above and that you are authorizing the use/release of the PHI as above;
2. This authorization is voluntary and not a condition of enrollment, eligibility, or claim payment;
3. The Authorized Person(s) may not be subject to federal/state privacy laws and they may further release the PHI;
4. You may revoke this authorization at any time by sending written notice to the Health Plan at the address on the reverse of this form. Your revocation will not affect any action previously taken in reliance on this authorization prior to the Health Plan’s receipt of your revocation.

**SIGNATURE OF MEMBER/PATIENT NAMED IN PART 1:**

<table>
<thead>
<tr>
<th>Print Name:</th>
<th>Relationship to Member:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>
Medicare Certification Form

Member Name: ________________________________________
Identification #: ______________________________________
Group #: ____________________________________________

Our records indicate that the member named above may be eligible for Medicare. We are sending this letter to both the subscriber and the employer, as the information below is needed to determine Medicare eligibility. Federal Law affects how we must handle any future claims for the Medicare-eligible member.

- **To the Subscriber:** Please complete Section C of this form and return it to us at: Medicare Certification; PO Box 80; Buffalo, NY 14240-0080. Please contact Customer Service at the number on the back of your identification card if you need assistance. We encourage you to provide the same Medicare information to your employer to ensure your records are up-to-date.

- **To the Employer:** Please complete Sections A and B of the form and return it to us at: Medicare Certification; PO Box 80; Buffalo, NY 14240-0080. After reviewing the Medicare information provided, we will make any applicable changes to the policy. If you (the employer) have at least 20 employees, you are required to provide the same health benefits under the same conditions to Medicare eligible employees and the Medicare eligible spouses of employees as you provide to employees and spouses who are not Medicare eligible.
MEDICARE CERTIFICATION FORM

Please complete the following information for the Medicare-eligible member:

Member Name: ________________________________
ID #: _______________________________________
Group #: _____________________________________

Section A: (To be completed by the employer)

Please check the box that indicates the total number of full and part-time employees during the past two calendar years to appropriately determine if your group is TEFRA or OBRA eligible. (TEFRA and OBRA are federal regulations which require group health coverage to be primary to Medicare if certain requirements are met.)

☐ Less than 20
☐ 20 - 99 (during 20 or more weeks of this year or last year)
☐ 100 or more (on 50% or more of the business days of this year or last year)

Please check and complete the response below that best suits the situation of the above-mentioned member:

☐ This member either retired from our employ on _______________________ or is the spouse of a retiree, and is therefore qualified to have Medicare as the primary payer and to remain covered by the group health plan.

☐ We do not have at least 20 employees, therefore, this member is qualified to remain covered by the group health plan and Medicare will be the primary payer.

☐ We do have at least 20 employees, and this member is considered an active employee, or the spouse of an active employee. Coverage will continue under the group health plan with the group health plan as primary payer over Medicare.

☐ We do have at least 20 employees and this member is considered an active employee or the spouse of an active employee, but this member has elected to have Medicare as the primary payer. Please cancel group health plan coverage for this member effective the date Medicare coverage begins.

☐ The member named above is not eligible for Medicare benefits for the following reason: ____________________________________________

Section B: (To be completed by the employer)

If and when the employment status of this employee changes, it is the employer's responsibility to notify our office so that membership information is kept up-to-date.

IMPORTANT:
The information provided in this letter authorizes us to put the member in the applicable product. Failure to respond to this request will cause automatic rejection of claims for dates of service on or after the employee or spouse's Medicare eligibility.

Please see your contract for more information.

_________________________________________ __
Employer’s Signature Date

Section C: (To be completed by the member)
If applicable, please provide the following information as it appears on the member’s Medicare Identification Card:

<table>
<thead>
<tr>
<th>Social Security Act</th>
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<tbody>
<tr>
<td><strong>Name of Beneficiary:</strong></td>
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<tr>
<td>__________________________</td>
</tr>
<tr>
<td><strong>Claim Number:</strong></td>
</tr>
<tr>
<td>__________________________</td>
</tr>
<tr>
<td><strong>Sex:</strong></td>
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<tr>
<td>__________________________</td>
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<tr>
<td><strong>Is Entitled to:</strong></td>
</tr>
<tr>
<td><strong>Hospital (Part A)</strong></td>
</tr>
<tr>
<td>__________________________</td>
</tr>
<tr>
<td><strong>Medical (Part B)</strong></td>
</tr>
<tr>
<td>__________________________</td>
</tr>
<tr>
<td><strong>Drug (Part D)</strong></td>
</tr>
<tr>
<td>__________________________</td>
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<tr>
<td><strong>Member’s Date of Birth:</strong></td>
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<tr>
<td>__________________________</td>
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<tr>
<td><strong>If Medicare coverage is due to disability, please give reason:</strong></td>
</tr>
<tr>
<td>__________________________</td>
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<tr>
<td>__________________________</td>
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<tr>
<td><strong>If Medicare coverage is due to End Stage Renal Disease, please specify first date of dialysis:</strong></td>
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<tr>
<td>__________________________</td>
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</tbody>
</table>

_________________________ **Member’s Signature** __________________________ **Date**
healthy changes

everything:

BlueCross BlueShield
of Western New York

This manual is intended as a guide for group administrators regarding BlueCross BlueShield policies and procedures and is subject to change at any time.

If BlueCross BlueShield amends, modifies or institutes a new policy or procedure that is inconsistent with the information contained in this manual, the amended, modified or new policy and procedure shall control.

If there is any inconsistency or conflict between this manual and the employers’ group remittance contract or group agreement, the subscriber contract or evidence of coverage, those documents shall control.