Not Just Coverage. Confidence.

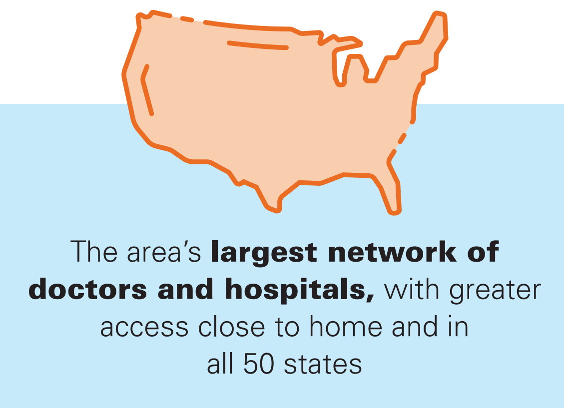
Your Benefit Plan Details

Group Name
Roofers Local 22

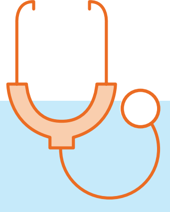
Welcome to Excellus BlueCross BlueShield!

Getting the most from your health plan is more important than ever. Excellus BCBS is here to bring together the coverage, programs and resources you need to be on your way to total physical, emotional and financial wellbeing.

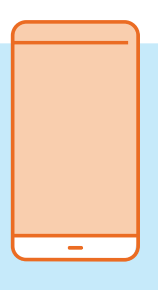
You can count on your Excellus BCBS plan for care when and where you need it:



The area's **largest network of doctors and hospitals,** with greater access close to home and in all 50 states



$0 copays for most preventive services such as an annual routine physical exam*, select vaccines, and important health screenings



Free digital support tools for answers anytime, anywhere, such as:

- Online member account
- Mobile app
- Estimate out-of-pocket medical costs
- Find a doctor, specialist or facility that accepts your plan

Find more answers and support at **ExcellusBCBS.com**

In this booklet you will find:

- A chart that summarizes this plan's unique benefits and coverage**
- Helpful information to help you get the most from your plan
- A glossary of terms to help you understand your coverage and options

* Does not include procedures, injections, diagnostic services, laboratory and X-ray services, or any other services not billed as preventive services.

**This benefit summary is not a contract or binding agreement; it is a summary of benefits and services.

Roofers Local 22

Signature Hybrid 1

Plan Features

Primary Care Physician (PCP)	Not Required
Referrals	Not Required
Out of network benefits	Covered
Student / Dependent Coverage	Covered to age 26
Domestic Partner	Not Covered
Coverage Period	01/01/25-12/31/25
Office visit copay (Primary Care Physician)	$30 In Network/ 40% Out of Network
Office visit copay (Specialist)	$50 In Network/ 40% Out of Network
Coinsurance	20% In Network/ 40% Out of Network
Deductible	In Network: $1,000 Single/$3,000 Family OON: $2,000 Single/$6,000 Family
Out of pocket maximum	In Network:$4,200 Single/$12,600 Family OON:$8,400 Single/$25,200 Family

Questions? For assistance call (800) 499-1275,
Call our TTYphone at 1 (800) 421-1220,
or visit us at www.ExcellusBCBS.com

Excellus BluePPO Signature Hybrid 1

$5/$45/$90 $0 Generics for Kids $0

Benefit Time Period: 01/01/2025 - 12/31/2025

ROOFERS LOCAL 22

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$1,000	$2,000	
Deductible - Family	$3,000	$6,000	Each individual does not exceed the single deductible.
Coinsurance	20%	40%	
Annual Out of Pocket Maximum - Single	$4,200	$8,400	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$12,600	$25,200	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$30 Copayment	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	$50 Copayment	40% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	$0 Copayment	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $1,000 Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	$50 Copayment	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	40% Coinsurance Subject to Deductible	
Radiation Therapy	$50 Copayment	40% Coinsurance Subject to Deductible	
Chemotherapy	$30 Copayment	40% Coinsurance Subject to Deductible	
Infusion Therapy Outpatient	Covered in Full	25% Coinsurance Subject to Deductible	Cost share applies to licensed services and infusion therapy separately.
Dialysis	Covered in Full	40% Coinsurance Subject to Deductible	
Mental Health Care	$30 Copayment $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$30 Copayment $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	25% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	Covered in Full	25% Coinsurance Subject to $50 Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	40% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP - $30 Copayment Specialist - $50 Copayment $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $50 Copayment	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $50 Copayment	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $30 Copayment	40% Coinsurance Subject to Deductible	
Infusion Therapy Services	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	Cost share applies to licensed services and infusion therapy separately.
Dialysis	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $30 Copayment $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	$0 Kids Copay applies to PCP and Specialist
Maternity Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Telehealth	PCP - $30 Copayment Specialist - $50 Copayment $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Covered in Full $0 PCP Copay for members to age 19.	Not Covered	Covers online internet consultations between the member and the providers who participate in our Telemedicine MDLive and, if applicable, Vori Health Program for medical, behavioral health, and physical therapy conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - $30 Copayment	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP - $30 Copayment Specialist - $50 Copayment $0 PCP Copay for members to age 19.	40% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $50 Copayment	40% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$50 Copayment	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	$50 Copayment	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	$50 Copayment	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $50 Copayment	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - $50 Copayment	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - $50 Copayment	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $50 Copayment	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$50 Copayment	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Preventive	N/A	N/A	
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - $30 Copayment	40% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - $0 Copayment	40% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - $30 Copayment	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Medical Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Covered	Covered	$4,000 Reimbursement Per Plan Year Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available due to a law or regulation in the state where the member resides.

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$250 Copayment	$250 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$250 Copayment	$250 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$60 Copayment	40% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$5/$45/$90 $0 Generics for Kids $0

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	2		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

ABILIFY
ABILIFY MYCITE
ACAMPROSATE CALCIUM
ACARBOSE
ACCOLATE
ACCUPRIL
ACCURETIC
ACEBUTOLOL HCL
ACETAZOLAMIDE
ACETAZOLAMIDE ER
ACTIGALL
ACTIVELLA
ACTONEL
ACTOPLUS MET
ACTOS
ADALAT CC
ADTHYZA
ADVAIR DISKUS
ADVAIR HFA
AFIRMELLE
AGGRENOX
AIRDUO DIGIHALER
AIRDUO RESPICLICK
AIRSUPRA
ALDACTAZIDE
ALDACTONE
ALENDRONATE SODIUM
ALFUZOSIN HCL ER
ALISKIREN
ALLOPURINOL
ALOGLIPTIN
ALOGLIPTIN-METFORMIN
ALOGLIPTIN-PIOGLITAZONE
ALORA
ALPHAGAN P
ALTACE
ALTAVERA
ALTOPREV
ALVESCO
ALYACEN

TRADE NAME

AMABELZ
AMANTADINE
AMARYL
AMETHIA
AMETHIA LO
AMETHYST
AMILORIDE HCL
AMILORIDE-HYDROCHLOROTHIAZIDE
AMIODARONE HCL
AMITRIPTYLINE HCL
AMLODIPINE BESYLATE
AMLODIPINE BESYLATE-BENAZEPRIL
AMLODIPINE-OLMESARTAN
AMLODIPINE-VALSARTAN
AMLODIPINE-VALSARTAN-HCTZ
AMOXAPINE
ANAFRANIL
ANGELIQ
ANNOVERA
ANORO ELLIPTA
ANTABUSE
ANTARA
APLENZIN
APRACLONIDINE HCL
APRI
APRISO
ARANELLE
ARICEPT
ARIPIPRAZOLE
ARIPIPRAZOLE ODT
ARMONAIR DIGIHALER
ARMOUR THYROID
ARNUITY ELLIPTA
ASACOL HD
ASENAPINE MALEATE
ASHLYNA
ASMANEX
ASMANEX HFA
ASPIRIN-DIPYRIDAMOLE ER
ASPIRIN-OMEPRAZOLE

Maintenance medications are typically prescribed for long-term use. This list provides examples of commonly prescribed maintenance medications required for purchase through the mail order program. It is not comprehensive. Coverage requirements and co-payments are based upon the specific rider chosen by the employer group. If you have any questions regarding this service, please call the Customer Care number on the back of your Member Card

Last Updated 10/2024

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

ASPRUZYO SPRINKLE
ATACAND
ATACAND HCT
ATELVIA
ATENOLOL
ATENOLOL-CHLORTHALIDONE
ATORVALIQ
ATORVASTATIN CALCIUM
ATROPINE SULFATE
ATROVENT HFA
AUBRA
AUBRA EQ
AUROVELA
AUROVELA 24 FE
AUROVELA FE
AVALIDE
AVAPRO
AVIANE
AVODART
AYGESTIN
AYUNA
AZASAN
AZATHIOPRINE
AZILECT
AZOPT
AZOR
AZULFIDINE
AZURETTE
BACLOFEN
BALCOLTRA
BALSALAZIDE DISODIUM
BALZIVA
BANZEL
BECONASE AQ
BEKYREE
BENAZEPRIL HCL
BENAZEPRIL-HYDROCHLOROTHIAZIDE
BENICAR
BENICAR HCT
BENZTROPINE MESYLATE

TRADE NAME

BETAGAN
BETAPACE
BETAPACE AF
BETAXOLOL HCL
BETIMOL
BETOPTIC S
BEVESPI AEROSPHERE
BEYAZ
BINOSTO
BISOPROLOL FUMARATE
BISOPROLOL-HYDROCHLOROTHIAZIDE
BLISOVI 24 FE
BLISOVI FE
BONIVA
BRENZAVVY
BREO ELLIPTA
BREYNA
BRIELLYN
BRILINTA
BRIMONIDINE TARTRATE
BRIMONIDINE TARTRATE-TIMOLOL
BRINZOLAMIDE
BROMOCRIPTINE MESYLATE
BUDESONIDE
BUDESONIDE-FORMOTEROL FUMARATE
BUMETANIDE
BUPROPION HCL
BUPROPION HCL SR
BUPROPION XL
BUSPIRONE HCL
BYSTOLIC
CABERGOLINE
CADUET
CALAN
CALAN SR
CALCIPOTRIENE
CALCIPOTRIENE-BETAMETHASONE
CALCIPOTRIENE-BETAMETHASONE DP
CALCITONIN-SALMON

Maintenance medications are typically prescribed for long-term use. This list provides examples of commonly prescribed maintenance medications required for purchase through the mail order program. It is not comprehensive. Coverage requirements and co-payments are based upon the specific rider chosen by the employer group. If you have any questions regarding this service, please call the Customer Care number on the back of your Member Card

Last Updated 10/2024

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

CALCITRIOL
CALCIUM ACETATE
CAMILA
CAMRESE
CAMRESE LO
CANASA
CANDESARTAN CILEXETIL
CANDESARTAN-HYDROCHLOROTHIAZID
CAPLYTA
CAPTOPRIL
CAPTOPRIL-HYDROCHLOROTHIAZIDE
CARBAMAZEPINE
CARBAMAZEPINE ER
CARBATROL
CARBIDOPA
CARBIDOPA-LEVODOPA
CARBIDOPA-LEVODOPA ER
CARBIDOPA-LEVODOPA-ENTACAPONE
CARDIZEM
CARDIZEM CD
CARDIZEM LA
CARDURA
CARDURA XL
CARTEOLOL HCL
CARTIA XT
CARVEDILOL
CARVEDILOL ER
CATAPRES
CATAPRES-TTS 1
CATAPRES-TTS 2
CATAPRES-TTS 3
CAZIANT
CELEXA
CELLCEPT
CELONTIN
CEQUA
CHATEAL
CHATEAL EQ
CHLORDIAZEPOXIDE-AMITRIPTYLINE
CHLOROQUINE PHOSPHATE

TRADE NAME

CHLOROTHIAZIDE
CHLORPROMAZINE HCL
CHLORTHALIDONE
CHOLESTYRAMINE LIGHT
CILOSTAZOL
CITALOPRAM HBR
CITRANATAL MEDLEY
CLIMARA
CLIMARA PRO
CLOBETASOL EMOLLIENT
CLOBETASOL EMULSION
CLOBETASOL PROPIONATE
CLOBEX
CLODAN
CLOMIPRAMINE HCL
CLONIDINE
CLONIDINE HCL
CLOPIDOGREL
COLAZAL
COLCHICINE
COLCRYS
COLESTID
COLESTIPOL HCL
COMBIGAN
COMBIPATCH
COMBIVENT RESPIMAT
COMTAN
CONJUPRI
COREG
COREG CR
CORGARD
CORMAX
COSOPT
COSOPT PF
COZAAR
CRESTOR
CREXONT
CROMOLYN SODIUM
CRYSELLE
CYCLOPENTOLATE HCL

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

CYCLOSET
CYCLOSPORINE
CYCLOSPORINE MODIFIED
CYMBALTA
CYRED
CYRED EQ
CYSTAGON
CYTOMEL
DABIGATRAN ETEXILATE
DALIRESP
DAPAGLIFLOZIN
DAPAGLIFLOZIN-METFORMIN ER
DAPSONE
DASATINIB
DASETTA
DAYSEE
DDAVP
DEBLITANE
DELESTROGEN
DELYLA
DELZICOL
DEMADEX
DEMSER
DEPAKOTE
DEPAKOTE ER
DEPAKOTE SPRINKLE
DEPO-ESTRADIOL
DESIPRAMINE HCL
DESMOPRESSIN ACETATE
DESOGESTREL-ETHINYL ESTRADIOL
DESOGESTR-ETH ESTRAD ETH ESTRA
DESVENLAFAXINE ER
DIBENZYLINE
DIGITEK
DIGOX
DIGOXIN
DILANTIN
DILANTIN-125
DILTIAZEM 12HR ER
DILTIAZEM 24HR ER

TRADE NAME

DILTIAZEM 24HR ER (CD)
DILTIAZEM 24HR ER (LA)
DILTIAZEM 24HR ER (XR)
DILTIAZEM HCL
DILT-XR
DIOVAN
DIOVAN HCT
DIPENTUM
DIPYRIDAMOLE
DISOPYRAMIDE PHOSPHATE
DISULFIRAM
DIURIL
DIVALPROEX SODIUM
DIVALPROEX SODIUM ER
DIVIGEL
DOFETILIDE
DONEPEZIL HCL
DONEPEZIL HCL ODT
DORZOLAMIDE HCL
DORZOLAMIDE-TIMOLOL
DOVONEX
DOXAZOSIN MESYLATE
DOXEPIN HCL
DRITHOCREME HP
DRIZALMA SPRINKLE
DROSPIRENONE-ETH ESTRA-LEVOMEF
DROSPIRENONE-ETHINYL ESTRADIOL
DROXIA
DUAKLIR PRESSAIR
DUETACT
DULERA
DULOXETINE HCL
DUOBRII
DURLAZA
DUTASTERIDE
DYAZIDE
DYRENIUM
EDARBI
EDARBYCLOR
EDECRIN

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

EFFER-K
EFFEXOR XR
EFFIENT
ELEPSIA XR
ELESTRIN
ELINEST
ELIQUIS
ELIXOPHYLLIN
EMOQUETTE
EMSAM
EMZAHH
ENALAPRIL MALEATE
ENALAPRIL-HYDROCHLOROTHIAZIDE
ENPRESSE
ENSKYCE
ENSTILAR
ENTACAPONE
ENTRESTO
EPANED
EPITOL
EPRONTIA
EPROSARTAN MESYLATE
EQUETRO
ERGOLOID MESYLATES
ERMEZA
ERRIN
ESCITALOPRAM OXALATE
ESTARYLLA
ESTRACE
ESTRADIOL
ESTRADIOL (ONCE WEEKLY)
ESTRADIOL (TWICE WEEKLY)
ESTRADIOL VALERATE
ESTRADIOL-NORETHINDRONE ACETAT
ESTRING
ESTROGEL
ETHACRYNIC ACID
ETHOSUXIMIDE
ETHYNODIOL-ETHINYL ESTRADIOL
ETIDRONATE DISODIUM

TRADE NAME

EVAMIST
EXELON
EXFORGE
EXFORGE HCT
EZALLOR SPRINKLE
EZETIMIBE
FALMINA
FANAPT
FARXIGA
FAYOSIM
FELBAMATE
FELBATOL
FELODIPINE ER
FEMLYV
FEMRING
FEMYNOR
FENOFIBRATE
FENOFIBRIC ACID
FETZIMA
FIBRICOR
FINASTERIDE
FLECAINIDE ACETATE
FLOMAX
FLOVENT DISKUS
FLOVENT HFA
FLUNISOLIDE
FLUOXETINE DR
FLUOXETINE HCL
FLUPHENAZINE HCL
FLUTICASONE PROPIONATE
FLUTICASONE PROPIONATE HFA
FLUTICASONE-SALMETEROL
FLUTICASONE-SALMETEROL HFA
FLUTICASONE-VILANTEROL
FLUVASTATIN ER
FLUVASTATIN SODIUM
FLUVOXAMINE MALEATE
FLUVOXAMINE MALEATE ER
FOLIC ACID
FORFIVO XL

Maintenance medications are typically prescribed for long-term use. This list provides examples of commonly prescribed maintenance medications required for purchase through the mail order program. It is not comprehensive. Coverage requirements and co-payments are based upon the specific rider chosen by the employer group. If you have any questions regarding this service, please call the Customer Care number on the back of your Member Card

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Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

FORMOTEROL FUMARATE
FORTAMET
FOSAMAX
FOSINOPRIL SODIUM
FOSINOPRIL-HYDROCHLOROTHIAZIDE
FUROSEMIDE
FYAVOLV
GABAPENTIN
GABAPENTIN ER
GABITRIL
GALANTAMINE ER
GALANTAMINE HBR
GALANTAMINE HYDROBROMIDE
GALLIFREY
GASTROCROM
GEMFIBROZIL
GEMMILY
GENERESS FE
GENGRAF
GEODON
GIANVI
GILDAGIA
GLIMEPIRIDE
GLIPIZIDE
GLIPIZIDE ER
GLIPIZIDE XL
GLIPIZIDE-METFORMIN
GLOPERBA
GLUCOPHAGE
GLUCOPHAGE XR
GLUCOTROL
GLUCOTROL XL
GLUMETZA
GLYBURIDE
GLYBURIDE MICRONIZED
GLYBURIDE-METFORMIN HCL
GLYNASE
GLYSET
GLYXAMBI
GRALISE

TRADE NAME

GUANFACINE HCL
GUANIDINE HCL
HAILEY
HAILEY 24 FE
HAILEY FE
HALOPERIDOL
HEATHER
HYDRALAZINE HCL
HYDREA
HYDROCHLOROTHIAZIDE
HYDROXYCHLOROQUINE SULFATE
HYDROXYUREA
HYZAAR
IBANDRONATE SODIUM
IMIPRAMINE HCL
IMIPRAMINE PAMOATE
IMPEKLO
IMURAN
IMVEXXY
INCASSIA
INCRUSE ELLIPTA
INDAPAMIDE
INDERAL LA
INDERAL XL
INNOPRAN XL
INPEFA
INSPRA
INTROVALE
INVEGA
INVOKAMET
INVOKAMET XR
INVOKANA
IOPIDINE
IPRATROPIUM BROMIDE
IPRATROPIUM-ALBUTEROL
IRBESARTAN
IRBESARTAN-HYDROCHLOROTHIAZIDE
IRENKA
ISOPTO CARPINE
ISOSORBIDE DINIT-HYDRALAZINE

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

ISOSORBIDE MONONITRATE ER
ISRADIPINE
ISTALOL
IYUZEH
JANUMET
JANUMET XR
JANUVIA
JARDIANCE
JASMIEL
JENCYCLA
JENTADUETO
JENTADUETO XR
JEVANTIQUE LO
JINTELI
JOLESSA
JULEBER
JUNEL
JUNEL FE
JUNEL FE 24
KAITLIB FE
KALLIGA
KARIVA
KATERZIA
KAZANO
KELNOR 1-35
KELNOR 1-50
KEPPRA
KEPPRA XR
KERENDIA
KLOR-CON
KLOR-CON 10
KLOR-CON 8
KLOR-CON M10
KLOR-CON M15
KLOR-CON M20
KLOR-CON SPRINKLE
KLOR-CON-EF
KOMBIGLYZE XR
K-PHOS NEUTRAL
K-PHOS NO.2

TRADE NAME

K-PHOS ORIGINAL
K-TAB ER
KURVELO
KYNMOBI
LABETALOL HCL
LAMICTAL
LAMICTAL (BLUE)
LAMICTAL (GREEN)
LAMICTAL (ORANGE)
LAMICTAL ODT
LAMICTAL ODT (BLUE)
LAMICTAL ODT (GREEN)
LAMICTAL ODT (ORANGE)
LAMICTAL XR
LAMICTAL XR (BLUE)
LAMICTAL XR (GREEN)
LAMICTAL XR (ORANGE)
LAMOTRIGINE
LAMOTRIGINE (GREEN)
LAMOTRIGINE (ORANGE)
LAMOTRIGINE ER
LAMOTRIGINE ODT
LAMOTRIGINE ODT (BLUE)
LAMOTRIGINE ODT (GREEN)
LAMOTRIGINE ODT (ORANGE)
LANOXIN
LARIN
LARIN 24 FE
LARIN FE
LARISSIA
LASIX
LATUDA
LAYOLIS FE
LEENA
LESCOL XL
LESSINA
LEVAMLODIPINE MALEATE
LEVETIRACETAM
LEVETIRACETAM ER
LEVOBUNOLOL HCL

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

LEVONEST
LEVONORGESTREL-ETH ESTRADIOL
LEVONORG-ETH ESTRAD ETH ESTRAD
LEVORA-28
LEVO-T
LEVOTHYROXINE SODIUM
LEVOXYL
LEXAPRO
LIALDA
LILLOW
LIOTHYRONINE SODIUM
LIPITOR
LISINOPRIL
LISINOPRIL-HYDROCHLOROTHIAZIDE
LITHIUM CARBONATE
LITHIUM CARBONATE ER
LITHOBID
LIVALO
LO LOESTRIN FE
LODOSYN
LOESTRIN
LOESTRIN FE
LOMEDIA 24 FE
LONHALA MAGNAIR REFILL
LONHALA MAGNAIR STARTER
LOPID
LOPREEZA
LOPRESSOR
LOPRESSOR HCT
LORYNA
LOSARTAN POTASSIUM
LOSARTAN-HYDROCHLOROTHIAZIDE
LOSEASONIQUE
LOTENSIN
LOTENSIN HCT
LOTREL
LOVASTATIN
LOW-OGESTREL
LOXAPINE
LO-ZUMANDIMINE

TRADE NAME

LURASIDONE HCL
LUTERA
LYBALVI
LYZA
MARLISSA
MARPLAN
MATZIM LA
MAXZIDE
MAXZIDE-25 MG
MEDROXYPROGESTERONE ACETATE
MEGACE ES
MEGESTROL ACETATE
MELODETTA 24 FE
MEMANTINE HCL
MEMANTINE HCL ER
MENEST
MENOSTAR
MERCAPTOPURINE
MESALAMINE
MESALAMINE DR
MESALAMINE ER
MESTINON
METFORMIN ER GASTRIC
METFORMIN HCL
METFORMIN HCL ER
METHAZOLAMIDE
METHIMAZOLE
METHOXSALEN
METHSUXIMIDE
METHYCLOTHIAZIDE
METHYLDOPA
METOLAZONE
METOPROLOL SUCCINATE
METOPROLOL TARTRATE
METOPROLOL-HYDROCHLOROTHIAZIDE
METYROSINE
MEXILETINE HCL
MIACALCIN
MIBELAS 24 FE
MICARDIS

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

MICARDIS HCT
MICROGESTIN
MICROGESTIN 24 FE
MICROGESTIN FE
MICROZIDE
MIDODRINE HCL
MIGLITOL
MILI
MIMVEY
MIMVEY LO
MINASTRIN 24 FE
MINIPRESS
MINITRAN
MINIVELLE
MINOXIDIL
MIRAPEX
MIRAPEX ER
MIRCETTE
MIRTAZAPINE
MITIGARE
MOEXIPRIL HCL
MOLINDONE HCL
MOMETASONE FUROATE
MONO-LINYAH
MONTELUKAST SODIUM
MULTIVITAMIN WITH FLUORIDE
MVC-FLUORIDE
MYCOPHENOLATE MOFETIL
MYSOLINE
NADOLOL
NAMENDA
NAMENDA XR
NAMZARIC
NARDIL
NASONEX
NATAZIA
NATEGLINIDE
NEBIVOLOL HCL
NECON
NEFAZODONE HCL

TRADE NAME

NEORAL
NESINA
NEUPRO
NEURONTIN
NEXLETOL
NEXTSTELLIS
NIACIN
NIACIN ER
NIACOR
NIASPAN
NICARDIPINE HCL
NIFEDIPINE
NIFEDIPINE ER
NIKKI
NIMODIPINE
NISOLDIPINE
NITRO-DUR
NITROGLYCERIN PATCH
NITRO-TIME
NOCDURNA
NORA-BE
NORETHINDRONE
NORETHINDRONE-E.ESTRADIOL-IRON
NORETHINDRON-ETHINYL ESTRADIOL
NORETHIN-ETH ESTRA-FERROUS FUM
NORGESTIMATE-ETHINYL ESTRADIOL
NORLIQVA
NORLYDA
NORLYROC
NORPACE
NORPACE CR
NORPRAMIN
NORTREL
NORTRIPTYLINE HCL
NORVASC
NP THYROID
NUVARING
NYLIA
NYMALIZE
OCELLA

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

OLANZAPINE
OLANZAPINE ODT
OLANZAPINE-FLUOXETINE HCL
OLMESARTAN MEDOXOMIL
OLMESARTAN-AMLODIPINE-HCTZ
OLMESARTAN-HYDROCHLOROTHIAZIDE
OLUX
OLUX-E
OMNARIS
ONGENTYS
ONGLYZA
ORACIT
ORAL CITRATE
ORSYTHIA
ORTHO MICRONOR
ORTHO TRI-CYCLEN
ORTHO TRI-CYCLEN LO
ORTHO-NOVUM
OSENI
OXCARBAZEPINE
OXCARBAZEPINE ER
OXSORALEN-ULTRA
OXTELLAR XR
PACERONE
PALIPERIDONE ER
PAMELOR
PAREMYD
PARLODEL
PARNATE
PAROXETINE CR
PAROXETINE ER
PAROXETINE HCL
PAROXETINE MESYLATE
PAXIL
PAXIL CR
PEGANONE
PENTASA
PENTOXIFYLLINE
PERFOROMIST
PERINDOPRIL ERBUMINE

TRADE NAME

PERPHENAZINE
PERPHENAZINE-AMITRIPTYLINE
PEXEVA
PHENELZINE SULFATE
PHENOXYBENZAMINE HCL
PHENYTEK
PHENYTOIN
PHENYTOIN SODIUM EXTENDED
PHEXXI
PHILITH
PHOSLYRA
PHOSPHOLINE IODIDE
PILOCARPINE HCL
PIMTREA
PINDOLOL
PIOGLITAZONE HCL
PIOGLITAZONE-GLIMEPIRIDE
PIOGLITAZONE-METFORMIN
PIRMELLA
PITAVASTATIN CALCIUM
PLAQUENIL
PLAVIX
POKONZA
PORTIA
POTASSIUM CHLORIDE
POTASSIUM CITRATE ER
PRADAXA
PRAMIPEXOLE DIHYDROCHLORIDE
PRAMIPEXOLE ER
PRAVACHOL
PRAVASTATIN SODIUM
PRAZOSIN HCL
PRECOSE
PREFEST
PREMARIN
PREMPHASE
PREMPRO
PRESTALIA
PREVALITE
PREVIFEM

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

PRIMIDONE
PRINIVIL
PRISTIQ
PROBENECID
PROBENECID-COLCHICINE
PROCARDIA XL
PROGESTERONE
PROMETRIUM
PROPAFENONE HCL
PROPAFENONE HCL ER
PROPRANOLOL HCL
PROPRANOLOL HCL ER
PROPRANOLOL-HYDROCHLOROTHIAZID
PROPYLTHIOURACIL
PROSCAR
PROTRIPTYLINE HCL
PROVERA
PROZAC
PULMICORT
PULMICORT FLEXHALER
PYRIDOSTIGMINE BROMIDE
PYRIDOSTIGMINE BROMIDE ER
QBRELIS
QNASL
QNASL CHILDREN
QTERN
QUARTETTE
QUDEXY XR
QUESTRAN LIGHT
QUETIAPINE FUMARATE
QUETIAPINE FUMARATE ER
QUFLORA
QUINAPRIL HCL
QUINAPRIL-HYDROCHLOROTHIAZIDE
QUINIDINE GLUCONATE
QUINIDINE SULFATE
RAJANI
RAMELTEON
RAMIPRIL
RANEXA

TRADE NAME

RANOLAZINE ER
RAPAFLO
RASAGILINE MESYLATE
RAZADYNE
RAZADYNE ER
RECLIPSEN
RELTONE
REMERON
REPAGLINIDE
REQUIP XL
RESTASIS
RESTASIS MULTIDOSE
REXULTI
RHOPRESSA
RILUTEK
RILUZOLE
RIOMET
RIOMET ER
RISEDRONATE SODIUM
RISEDRONATE SODIUM DR
RISPERDAL
RISPERIDONE
RISPERIDONE ODT
RIVASTIGMINE
RIVELSA
ROCALTROL
ROCKLATAN
ROPINIROLE ER
ROPINIROLE HCL
ROSUVASTATIN CALCIUM
ROWEEPRA
ROZEREM
RUFINAMIDE
RYTARY
RYTHMOL SR
SAFYRAL
SANDIMMUNE
SAPHRIS
SAVAYSA
SAVELLA

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

SAXAGLIPTIN HCL
SAXAGLIPTIN-METFORMIN ER
SEASONIQUE
SECUADO
SEEBRI NEOHALER
SEGLUROMET
SELEGILINE HCL
SEREVENT DISKUS
SEROQUEL
SEROQUEL XR
SERTRALINE HCL
SETLAKIN
SFROWASA
SHAROBEL
SIKLOS
SILODOSIN
SIMBRINZA
SIMLIYA
SIMPESSE
SIMVASTATIN
SINEMET 10-100
SINEMET 25-100
SINEMET 25-250
SINEMET CR
SINGULAIR
SITAGLIPTIN
SITAGLIPTIN-METFORMIN
SLYND
SOAANZ
SORILUX
SORINE
SOTALOL
SOTALOL AF
SOTYLIZE
SPIRIVA HANDIHALER
SPIRIVA RESPIMAT
SPIRONOLACTONE
SPIRONOLACTONE-HCTZ
SPRINTEC
SPRITAM

TRADE NAME

SRONYX
STALEVO 100
STALEVO 125
STALEVO 150
STALEVO 200
STALEVO 50
STALEVO 75
STARLIX
STEGLATRO
STEGLUJAN
STIOLTO RESPIMAT
SULAR
SULFASALAZINE
SULFASALAZINE DR
SYEDA
SYMBICORT
SYMBYAX
SYNJARDY
SYNJARDY XR
SYNTHROID
TABLOID
TACLONEX
TAMSULOSIN HCL
TAPAZOLE
TARINA 24 FE
TARINA FE
TARINA FE 1-20 EQ
TARKA
TASMAR
TAYTULLA
TAZAROTENE
TAZORAC
TAZTIA XT
TEGRETOL
TEGRETOL XR
TEKTURNA
TEKTURNA HCT
TELMISARTAN
TELMISARTAN-AMLODIPINE
TELMISARTAN-HYDROCHLOROTHIAZID

Maintenance medications are typically prescribed for long-term use. This list provides examples of commonly prescribed maintenance medications required for purchase through the mail order program. It is not comprehensive. Coverage requirements and co-payments are based upon the specific rider chosen by the employer group. If you have any questions regarding this service, please call the Customer Care number on the back of your Member Card

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Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

TEMOVATE
TENORETIC 100
TENORETIC 50
TENORMIN
TERAZOSIN HCL
THALITONE
THEO-24
THEOPHYLLINE
THEOPHYLLINE ANHYDROUS
THEOPHYLLINE ER
THIORIDAZINE HCL
THIOTHIXENE
THYQUIDITY
TIADYLT ER
TIAGABINE HCL
TIAZAC
TICLOPIDINE HCL
TIKOSYN
TILIA FE
TIMOLOL MALEATE
TIMOPTIC
TIMOPTIC OCUDOSE
TIMOPTIC-XE
TIOTROPIUM BROMIDE
TIROSINT
TIROSINT-SOL
TOFRANIL
TOLCAPONE
TOPAMAX
TOPIRAMATE
TOPIRAMATE ER
TOPROL XL
TORSEMIDE
TRADJENTA
TRANDOLAPRIL
TRANDOLAPRIL-VERAPAMIL ER
TRANYLCYPROMINE SULFATE
TRAZODONE HCL
TRELEGY ELLIPTA
TRI FEMYNOR

TRADE NAME

TRIAMCINOLONE ACETONIDE
TRIAMTERENE
TRIAMTERENE-HYDROCHLOROTHIAZID
TRIBENZOR
TRI-ESTARYLLA
TRIFLUOPERAZINE HCL
TRIHEXYPHENIDYL HCL
TRIJARDY XR
TRI-LEGEST FE
TRILEPTAL
TRI-LINYAH
TRI-LO-ESTARYLLA
TRI-LO-MARZIA
TRI-LO-MILI
TRI-LO-SPRINTEC
TRI-MILI
TRIMIPRAMINE MALEATE
TRI-PREVIFEM
TRI-SPRINTEC
TRIVORA-28
TRI-VYLIBRA
TRI-VYLIBRA LO
TROKENDI XR
TROPICAMIDE
TRUSOPT
TULANA
TURQOZ
TWIRLA
TWYNSTA
TYDEMY
ULORIC
UNITHROID
UROCIT-K
UROQID-ACID NO.2
UROXATRAL
URSO
URSO FORTE
URSODIOL
VAGIFEM
VALCYTE

Maintenance Medication List:
Purchase Required through a Mail Order Pharmacy

TRADE NAME

VALGANCICLOVIR HCL
VALPROIC ACID
VALSARTAN
VALSARTAN-HYDROCHLOROTHIAZIDE
VASERETIC
VASOTEC
VECTICAL
VELIVET
VENLAFAXINE BESYLATE ER
VENLAFAXINE HCL
VENLAFAXINE HCL ER
VERAPAMIL ER
VERAPAMIL ER PM
VERAPAMIL HCL
VERAPAMIL SR
VERELAN
VERELAN PM
VERKAZIA
VERQUVO
VESTURA
VEVYE
VIENVA
VIGAFYDE
VIIBRYD
VILAZODONE HCL
VIORELE
VITAMIN D2
VIVELLE-DOT
VRAYLAR
VTAMA
VUITY
VYFEMLA
VYLIBRA
WELLBUTRIN SR
WELLBUTRIN XL
WERA
WIXELA INHUB
WYMZYA FE
WYNZORA
XARELTO

TRADE NAME

XELPROS
XHANCE
XIGDUO XR
XULANE
YASMIN 28
YAZ
YUPELRI
YUVAFEM
ZAFEMY
ZAFIRLUKAST
ZARAH
ZARONTIN
ZELAPAR
ZENCHENT
ZESTORETIC
ZESTRIL
ZETONNA
ZIAC
ZILEUTON ER
ZIPRASIDONE HCL
ZOCOR
ZOLOFT
ZONEGRAN
ZONISADE
ZONISAMIDE
ZONTIVITY
ZORYVE
ZOVIA 1-35
ZUMANDIMINE
ZYFLO
ZYFLO CR
ZYLOPRIM
ZYPREXA
ZYPREXA ZYDIS

Excellus BCBS: Excellus BluePPO Signature Hybrid 1

A nonprofit independent licensee of the BlueCross BlueShield Association

Coverage Period: 01/01/2025 - 12/31/2025

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

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

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,000 Individual/$2,000 Two Person/$3,000 Family; Out-of-Network: $2,000 Individual/$4,000 Two Person/ $6,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $4,200 Individual/$8,400 Two Person/$12,600 Family; Out-of-Network: $8,400 Individual/$16,800 Two Person/ $25,200 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Costs for premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copay/visit No Charge for Members to age 19 Deductible does not apply	40% Coinsurance	None
	Specialist visit	$50 Copay/visit Deductible does not apply	40% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: 40% Coinsurance Adult Immunizations: 40% Coinsurance Well Child Visit: No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.1 Exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: $50 Copay/visit X-Ray: Deductible does not apply Blood Work: No Charge Blood Work: Deductible does not apply	X-Ray: 40% Coinsurance Blood Work: 40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	$50 Copay/visit Deductible does not apply	40% Coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.excellusbcbs.com/rxlist	Tier 1 (Generic drugs)	$5/prescription retail, $10/ prescription mail order No Charge Members to age 19 Deductible does not apply	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription Preauthorization required for certain prescription drugs. If you don't get a preauthorization, you must pay the entire cost and submit a claim to us for reimbursement.
	Tier 2 (Preferred brand drugs)	$45/prescription retail, $90/ prescription mail order Deductible does not apply	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$90/prescription retail, $180/ prescription mail order Deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care	$250 Copay/visit Deductible does not apply	$250 Copay/visit Deductible does not apply	None
	Emergency medical transportation	$250 Copay/visit Deductible does not apply	$250 Copay/visit Deductible does not apply	None
	Urgent care	$60 Copay/visit Deductible does not apply	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay/visit Deductible does not apply	40% Coinsurance	None
	Inpatient services	20% Coinsurance	40% Coinsurance	
If you are pregnant	Office visits	No Charge	40% Coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	No Charge Deductible does not apply	25% Coinsurance	Deductible is limited to $50 Out-of-Network
	Rehabilitation services	$50 Copay/visit Deductible does not apply	40% Coinsurance	45 Visits per plan year limit
	Habilitation services	$50 Copay/visit Deductible does not apply	40% Coinsurance	45 Visits per plan year limit
	Skilled nursing care	20% Coinsurance	40% Coinsurance	45 Days per plan year limit
	Durable medical equipment	20% Coinsurance	40% Coinsurance	None
	Hospice services	No Charge Deductible does not apply	40% Coinsurance	Family bereavement counseling limited to 5 Visits per plan year
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	

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

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Child)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:

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

Peg is Having a Baby

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$2,010
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,170**

Managing Joe's type 2 Diabetes

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,290**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$750
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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

Notice of Nondiscrimination

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

The Health Plan:

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

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

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

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

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

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

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

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

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

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

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

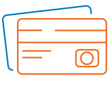
Member Card(s)
View or order

Claims
Submit, view and download

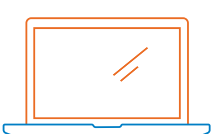
Find Providers
Find in-network doctors or specialists

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

Benefits and Coverage
View a summary



Get Rewards
Access available spending and rewards programs



Go Paperless

Receive available documents electronically.

Register or log in today

Visit ExcellusBCBS.com

Scan the QR code with your smartphone camera

Take your plan with you 24/7

Download the app!

5 easy steps

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

1. **Have your member card handy**

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

3. **Complete registration**

4. **Choose username and password**

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

New member? Or new plan year?

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

Thank you for being an Excellus BCBS member!

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注意：如果您说中文，我们可为您提供免费的语言协助。请参见随附的文件以获取我们的联系方式。

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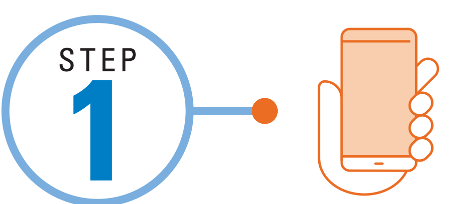
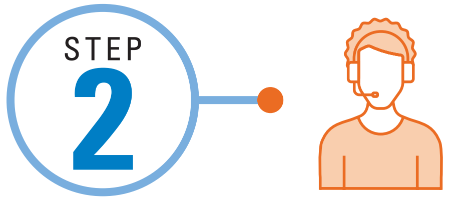
PRESCRIPTION HOME DELIVERY

SIGNING UP IS AS EASY AS 1, 2, 3

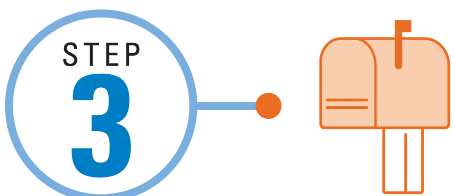


Call a pharmacy

Wegmans Home Delivery: (800) 586-6910
or visit Wegmans.com/Pharmacy
Express Scripts: (855) 315-5220
or visit Express-Scripts.com



Speak to a representative



Rx delivered right to your mailbox

Consider home delivery if you:

- Would like to receive a 90-day supply all at once.
- Take the same medication(s) every month.
- Need help managing your family's prescriptions.

Home delivery of prescriptions is safe and confidential

- Insulated packaging protects your medications from the sun, rain and cold.
- Discreet packaging does not reveal contents.
- Delivery straight to your mailbox.

Automatic refill option. Free standard shipping. Express delivery available. Pharmacists available to answer questions.

Call today!

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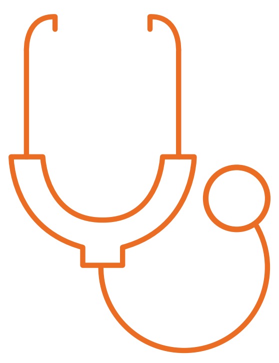
B-6342/17934-23Rx REV 07/23

KNOW WHERE TO GET CARE



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

WHERE TO GO	COST	CHOOSING THE BEST OPTION
Primary Care Physician	$	Your doctor should be your **first choice** for routine medical care or minor illnesses or injuries that are not an emergency. You may have an office visit copay depending on your plan. **TIP:** If you can't make it to their office, you might be able to schedule a remote visit with your doctor through phone or video connection, known as telehealth. Check with your primary care physician to see if they offer this option.
Telemedicine	$	If your doctor isn't available for minor medical or behavioral health needs, telemedicine may be an option for you. Telemedicine gives you fast and convenient access to a doctor 24/7/365 wherever you are through your phone, tablet, or computer. Register today at Member.ExcellusBCBS.com **Medical Telemedicine for:** • Allergies • Asthma • Cold & Flu • Constipation • Diarrhea • Fever • Joint Aches • Nausea • Pink Eye • Rashes • And more **Behavioral Health Telemedicine for:** • Addictions • Anxiety • Bipolar disorders • Depression • Eating disorders • Grief and loss • LGBTQ support • Panic disorders • Stress • And more
URGENT CARE **Urgent Care**	$$	If your medical issue is not life threatening and your doctor isn't available, you can visit an urgent care center and get the care you need. • Minor cuts, bruises or burns • Muscle strains or sprains • Cold and flu treatment
Emergency Room	$$$	You should only go to the emergency room if you have a serious or potentially life-threatening medical condition. Call 911 for assistance. Do not try to drive yourself there.

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B-7255 / 17259-23M REV 01/23

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

Annual OB/GYN Visit

Colorectal Cancer Screening

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

Download the Excellus BCBS app and register your online account.

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

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B-7332/15926-22M

Telemedicine for Medical and Behavioral Health Care

THE DOCTOR WILL SEE YOU NOW. WHEREVER. WHENEVER.

If your doctor isn't available, telemedicine may be an option for you. Telemedicine gives you fast access to medical and behavioral health care 24/7/365, from the comfort of your home, desk, or hotel room. **All you need to do is activate it through your online member account and download the MDLIVE app.**

Rest assured, our health care professionals deliver the same quality of care you receive from your own doctor, via your phone, tablet, or computer.

When do you use telemedicine?

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

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

Adults

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

Children

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

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

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

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

Here are some conditions people rely on behavioral health telemedicine for:

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

Telemedicine visits with MDLIVE may be covered in the following ways:

Plan Type	Telemedicine Cost Share
Copay	Covered in full
Hybrid / Deductible Non-HSA	If your doctor's visits are subject to deductible, a telemedicine visit will be covered in full after deductible
	If your doctor's visits are a copay with no deductible, a telemedicine visit will be covered in full
Deductible HSA	Covered in full after deductible
Note: This is not a contract. It is intended to highlight the coverage for most plan options. Please refer to your contract for your plan's benefits.	

*If you haven't met your deductible, you will pay the allowable charge of $50. The allowable charge does not apply to Behavioral Health services. The allowable costs for the Behavioral Health services vary but do not exceed $180. This means a member who has not met their deductible will not pay more than $180.

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

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

APP - Download the MDLIVE app

TEXT - EXCELLUS to 635483 (Message and data rates may apply.)

VOICE - Call 1-866-692-5045

DID YOU KNOW?

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

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

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

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

[2] Based on MDLIVE data, 2016.

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

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

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B-6675 / 17633-23M REV 04/23

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Important Facts Regarding Your Authorization to Share Protected Health Information

- In order to comply with Federal HIPAA regulations health plans must obtain a member's permission to share his/her protected health information with any other person. There are limited exceptions to this.

- As permitted by law, we will continue to communicate to providers of care involved in your treatment: (1) our payment activities in connection with your claims, (2) your enrollment in our health plan and (3) your eligibility for benefits.

- Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information for sexually transmitted diseases, abortion, and drug or alcohol abuse unless the child specifically authorizes the release of such information.

- This form is used to authorize us to share your protected health information. Each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period.

- We will NOT disclose information relating to genetic testing, substance use disorder, mental health, abortion, and sexually transmitted disease information unless you initial the corresponding condition in Part D. If you would like to authorize us to release information regarding HIV/AIDS, New York State requires that a different form be completed. To obtain a copy of this form, please contact our office at the telephone number listed on your identification card, or access the form at the following website: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm.

- If you need additional forms, you may copy this form, contact our office at the telephone number listed on your identification card or visit our Web site at https://www.excellusbcbs.com and search for "Manage Your Privacy".

- Please ensure you have fully completed the form so that we may honor your request.

RETAIN A COPY FOR YOUR RECORDS

AUTHORIZATION TO EXCELLUS HEALTH PLAN, INC. ("HEALTH PLAN") TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

☐ **Check here only if you are authorizing access to psychotherapy notes. If checked, this form cannot be used for any other purpose. You must complete a separate form for authorizing access to any other information. If this box is checked, skip Part D.**

PLEASE PRINT

PART A: MEMBER/INDIVIDUAL WHO IS THE SUBJECT OF THE INFORMATION TO BE DISCLOSED				
LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION # - located on ID card(s)
CURRENT ADDRESS		CITY		STATE/ZIP CODE

PART B: HEALTH PLAN CAN SHARE MY INFORMATION WITH THE FOLLOWING PERSON(S)	
NAME OF PERSON/ORGANIZATION	ADDRESS
NAME OF PERSON/ORGANIZATION	ADDRESS

PART C: REASON FOR MEMBER/INDIVIDUAL (PART A) AUTHORIZING DISCLOSURE

☐ At my request ☐ Other: ____

PART D: HEALTH PLAN CAN SHARE THE FOLLOWING INFORMATION *(select D-1 **or** D-2 and if applicable, D-3)*
NOTE: Skip this section if psychotherapy was checked at the top of this form

D-1. ☐ I would like you to disclose any information requested by the person or entity named in Part B. This includes information in Part D-3 (below) only if I placed my initials next to the condition. If my initials do not appear in D-3, information related to those conditions will not be disclosed.

- OR –

D-2. I would like to limit the disclosure of information to a specific type of information, provider, condition or date(s). If this area is blank I do not wish to limit the disclosure of my information.

☐ Enrollment *(e.g. eligibility, address, dependents, birth date)*
☐ Benefit *(e.g. benefit coverage, usage, limits)*
☐ Claim *(e.g. status, provider, dates, payment, diagnosis)*
☐ Clinical records *(e.g. doctor/facility, case management)*
☐ Other limitation: ___________________________________
☐ Date Range ______________ to ______________

- AND, IF APPLICABLE -

D-3. Unless specifically indicated below, information will not be disclosed related to the following conditions. If I have placed my initials next to one or more of these conditions, the Health Plan is authorized to disclose information related to those conditions.

_____ Genetic testing
_____ Sexually transmitted diseases
_____ Substance use disorder
_____ Abortion
_____ Mental health *(excluding psychotherapy notes)*

Note: A separate form must be completed in order to authorize release of information related to HIV/AIDS. The NYS approved form can be found at http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm

CONTINUED ON THE NEXT PAGE

PART E: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

I understand that:

- I can revoke this authorization at any time by writing to the Health Plan at the address listed below except this revocation would not affect any action taken by the Health Plan in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.
- Health Plan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on my giving this authorization.
- Unless you receive revocation in writing, this authorization will be valid until the date specified here: _________________

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form.

Signature: ____ **Date:** ____________________________

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: ____

Personal Representative Signature ____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other * __________________________

** You must provide documentation supporting your legal authority to act on behalf of the member*

RETURN TO:

Excellus Health Plan
P.O. Box 21146
Eagan, MN 55121

or Fax: 315-671-7079

Please keep a copy for your records

Notice of Nondiscrimination

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

The Health Plan:

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

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

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

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

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

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

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

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

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l’italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

A nonprofit independent licensee of the Blue Cross Blue Shield Association

FOR INTERNAL USE ONLY

HIOS ID# ____________________

EC ____________________

CONFIDENTIAL

Commercial Group Health Insurance Application/Change Form

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

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

Check Desired Action
☐ Add ☐ Cancel ☐ Change

Employer Name ____________________ Association/Chamber Name (if applicable) ____________________

Group Administrator's Signature (required) ____________________ Date ________

Employee Number ____________________ Department Number ____________________

Medical Information

Medical Group Number (8 digits) ____________________

Subgroup ________ Class ________

Who's covered?
☐Self Only
☐Self & Child(ren)
☐Self & Spouse/Domestic Partner
☐Family

______ / ______ / ______
Medical Effective Date

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

Medical Plan Selection

☐ (DAB) Signature Series Hybrid 1 Opt 1

Section 2: Subscriber's Information

Last Name ____________________

First Name ____________________

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

Street Address ____________________

City ____________________ **State** ________

Zip Code ____________________ **Phone** ____________________

Birthdate: ______ / ______ / ______

Gender:
☐Male
☐Female
☐Gender X

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

Social Security Number** ____________________

Date of Hire/Rehire: ______ / ______ / ______

Retirement Date: ______ / ______ / ______

☐Age 65+ ☐Disability
☐End Stage Renal *

Subscriber's Medicare Number (if applicable) ____________________

______ / ______ / ______
Medicare Part A Effective Date

______ / ______ / ______
Medicare Part B Effective Date

Section 3: Reason for enrollment or change
To be completed by the Group Administrator Not required for cancelations

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

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

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

☐Involuntary loss of coverage ☐Former dependent regains eligibility

Date of Event ___ , ___ , ______

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

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

☐Disability ☐Dependent Reached Max Age ☐ Other: ______________________________

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

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

Subscriber

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

Cancel Codes:

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

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

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

* = Not eligible for COBRA

Dependent(s)

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

* = Not eligible for COBRA

Cancel Codes:

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

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

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

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

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

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

Gender: ☐Male ☐Female ☐Gender X **Birthdate** ______ , _______ , _________

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

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

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

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

Part A Effective Date: ___ , ___ , ____ Part B Effective Date: ___ , ___ , ____

Medicare Number (if applicable)

↓ Additional Dependent(s) ↓

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other__________________________

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

Gender: ☐Male ☐Female ☐Gender X **Birthdate** ______ , _______ , _________

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

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

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

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

Part A Effective Date: ___ , ___ , ____ Part B Effective Date: ___ , ___ , ____

Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other____________________

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

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

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

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

____________________ Part A Effective Date: ___ / ___ / ____ Part B Effective Date: ___ / ___ / ____
Medicare Number (if applicable)

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

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

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

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

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

What is the name of the other carrier? ______________________________

Are you keeping the coverage? ☐Yes ☐No

If no, when will the coverage end? ☐Medical: ____ / ____ / ______ ☐Dental: ____ / ____ / ______

Policyholder's name ______________________________ ID#(s) ______________________________

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

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

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).
I hereby accept responsibility for payment of any portion of the premium.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to
you by your employer.
EXCLUSIVE PROVIDER ORGANIZATION (EPO) I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO. **PREFERRED PROVIDER ORGANIZATION (PPO)** I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

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

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

Subscriber Signature ____ **Date** ____________________

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

Instructions for completing the Group Health Insurance Application/Change Form

Section 1: Employer Group & Benefit Information
This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical, dental and/or vision group numbers and information must be populated. Select who you need coverage for on the medical, dental and/or vision plan(s). Next, select the medical, dental and/or vision plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator. Indicate the subscriber's status.

Section 2: Subscriber's Information
This section should be completed by the Subscriber. **We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act. * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

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

Section 3: Reason for enrollment or change
Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?
If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

Section 5: Information about who you would like coverage for (dependent information)
Please include information about all the people who you would like coverage for.
Use an additional application or addendum if more than three dependents need coverage.
If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.
Qualified guidelines for coverage include:

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

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

Section 6: Other coverage information (Required)
Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 7: Release
Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.

Health Plan Terms

To help you better understand our plans and your coverage, here are a few definitions* for frequently used health care terms.

Primary Care Physician (PCP)

A doctor who serves as your health care manager and coordinates virtually all of the health care services you routinely receive. Some plans do not require you to choose a PCP.

Referral

Instructions provided by a PCP for specialty care. Most plans do not require referrals.

In-network coverage

The coverage available when you receive services from a provider who participates in your health plan.

Out-of-network coverage

The coverage available when you receive services from a provider who does not participate in your health plan. Some plans may not include out-of-network coverage.

Out-of-area

Describes when you receive services while outside the geographic service area of your health plan. Your plan benefits may differ if you live or work beyond the geographic service area.

Copay

A dollar amount due at the time you receive certain services. A typical example would be an office visit copay due when visiting your physician's office for treatment.

Allowed Amount

The maximum amount your health plan will pay for a specific service. In-network providers agree to accept the allowed amount as payment in full.

Coinsurance

A cost-sharing method that requires you pay a percentage of the allowed amount for certain medical services.

Deductible

A set dollar amount you pay for services you receive before your insurer will make a payment.

Out-of-pocket maximum

The maximum amount of copays, deductible and coinsurance payments that you will pay for health services each calendar year.

*Some definitions may vary slightly by plan. In case of a conflict between your legal plan documents and this information, the plan documents will govern.

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