Empire BlueCross BlueShield

An Anthem Company

Choosing and using your plan

Your guide to open enrollment and making the most of your benefits

Empire PPO with HSA-Blue Access
Nassau County
Effective January 1, 2022

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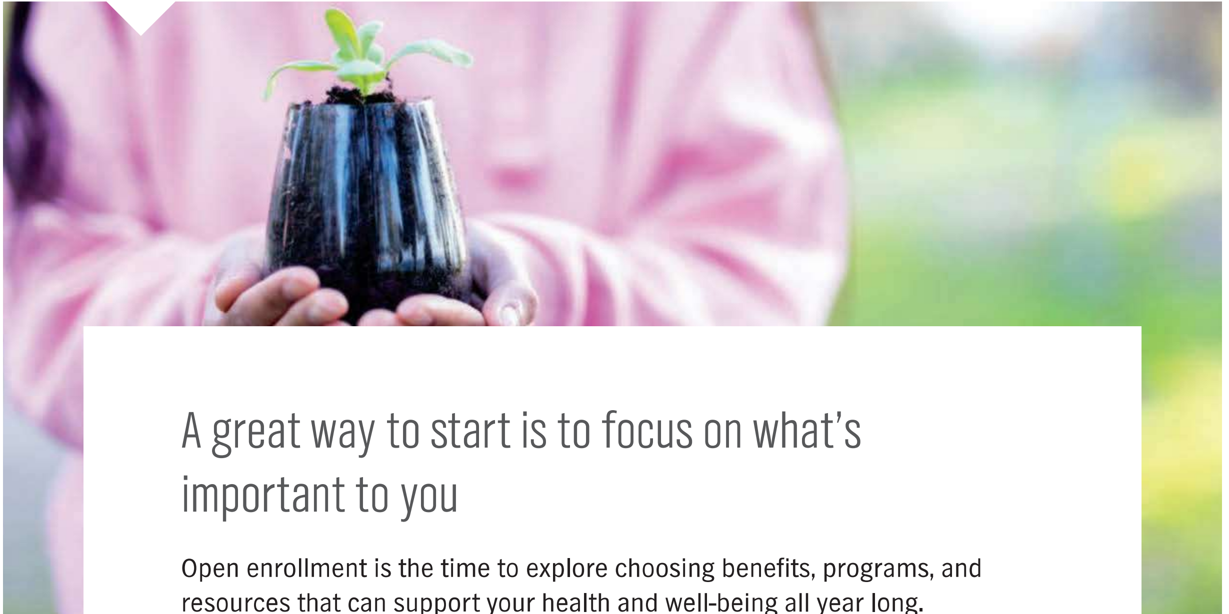
This guide is for information purposes only. You must enroll in a plan for your benefits to start.

It's time to choose your plan



A great way to start is to focus on what's important to you

Open enrollment is the time to explore choosing benefits, programs, and resources that can support your health and well-being all year long.

This guide was created to help you understand our plans. It also has tips, tools, and resources that can help you reach your health and wellness goals when you become a member. Save it to help you make the most of your benefits throughout the year.

Save this guide

You will find tips on how to make the most of your benefits and save on healthcare costs throughout the year.

Time to review your plan

A great way to start is to focus on what's important to you

Open enrollment is the time to explore your benefits, programs, and resources that can support your health and well-being all year long.

This guide was created to help you understand your plan. It also has tips, tools, and resources that can help you reach your health and wellness goals when you become a member. Save it to help you make the most of your benefits throughout the year.

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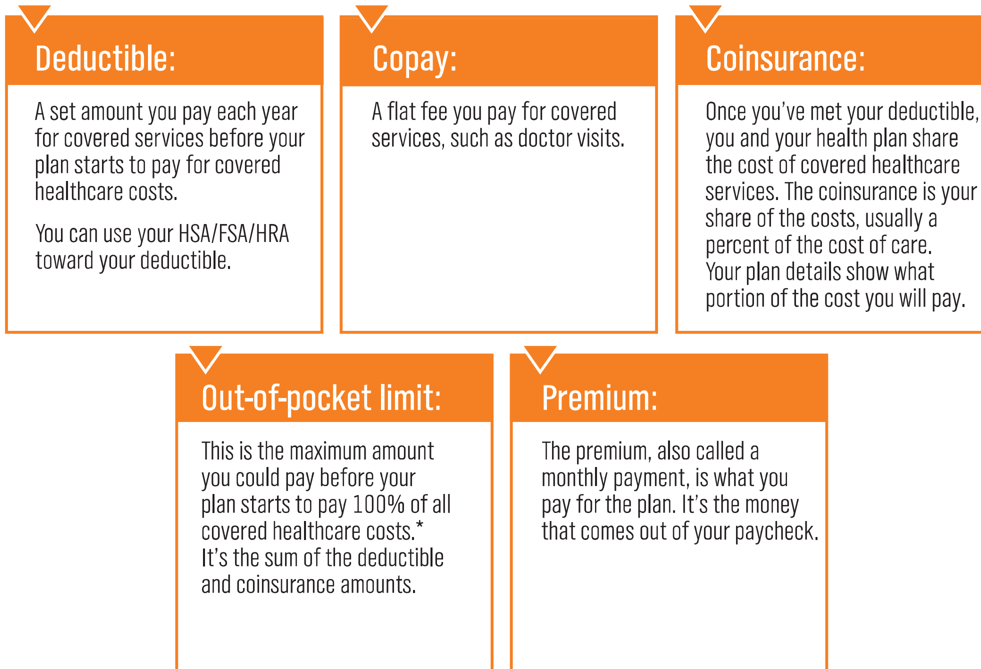
How to enroll

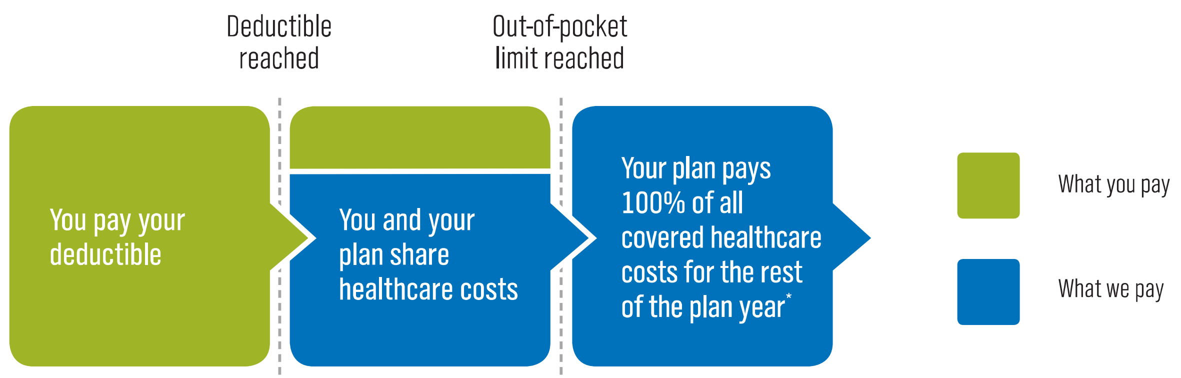
Your benefits administrator or human resources representative will contact you soon with specific enrollment instructions for your organization.

The basics of your health plan

Understanding healthcare terms



What you pay and what your plan pays



This chart is only an example. Your actual cost share will depend on your plan, the service you receive, and the doctor you choose. Refer to your plan details to see your actual share of the cost.

* There are plans that require you to pay a copay at the time of service.

Explore your plan

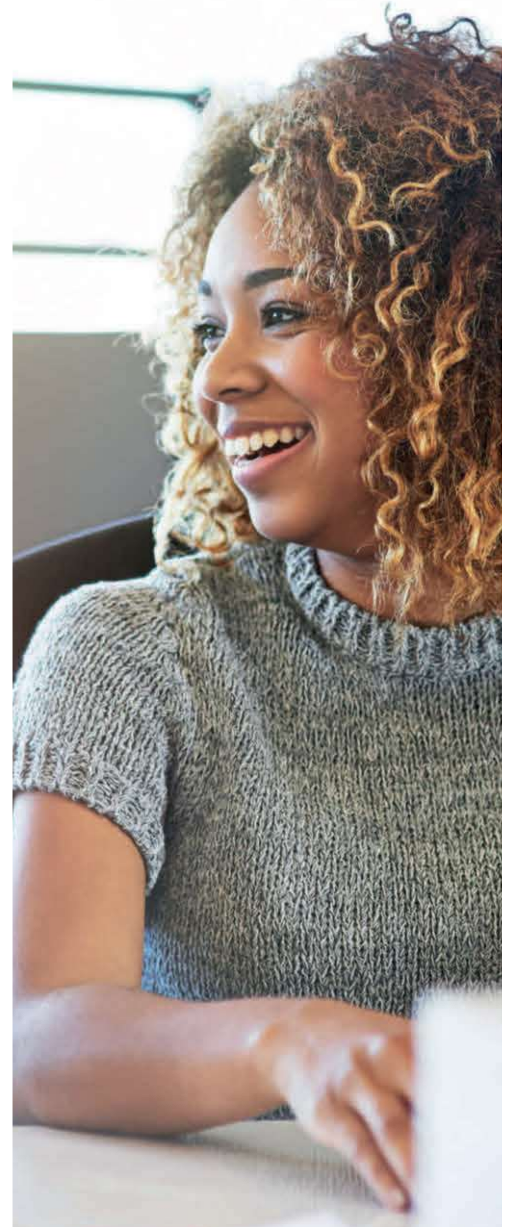
Review the health plan below to find the right fit for your needs.

Health savings account (HSA)

An HSA allows you to set aside pretax dollars to pay for care when you need it. You can use money in the account to pay for qualified medical expenses, such as hospital visits, prescription drugs, or copays for a doctor visit.[1]

- Once you pay your deductible, you will pay a percentage of the total cost (called coinsurance) anytime you receive care for a covered service. Your plan will cover the rest.
- The money you put into your HSA, any interest you earn, and the money you take out to pay for healthcare is tax-free.
- You can contribute up to $3,650 for an individual and $7,300 for a family.[2]
- If you are 55 or older, you can contribute an extra $1,000 a year.
- You can also invest your HSA funds. Once you have more than $1,000 in your account, anything above that amount can be invested to build solid, long-term savings.

Watch our HSA Basics video for details.



1 For a full list of qualified expenses for an individual, visit **empireblue.com/qme.**
2 Veterans who have received medical benefits from Veterans Affairs due to a service-connected disability are eligible to receive or make HSA contributions. Visit the IRS website at irs.gov/irb/2004-33_IRB for details.

Pharmacy benefits

What your plan will cover

Your pharmacy plan includes:

- Different drug lists. Be sure to check the lists for your medicines, and the brand-name drugs and generics that are included in your plan.
  - Visit **fm.formularynavigator.com/FBO/143/National_3_Tier_EBCBS.pdf** for the Drug List.
- Most specialty drugs are covered if you have an ongoing health issue or a serious illness.

How your pharmacy benefits work

You and your plan share the costs

You and your plan share the cost of covered medicine. Depending on the plan you choose, you will either have a copay or coinsurance.

- **Copay:** A flat fee you pay for medicine. Your copay is based on which tier the drug is on. See the *Save money with Tier 1* drugs section for details.
- **Coinsurance:** Your share of the drug costs. It is a percent of the cost of the medicine, which can vary from pharmacy to pharmacy.

Pharmacy benefits

Save money with Tier 1 drugs

Prescription medicines or drugs are listed in groups called tiers. Your cost is based on which tier the drug is in. Tiers 1 and 2 usually include low-cost brand-name and generic drugs. You will save the most money when you use Tier 1 drugs.

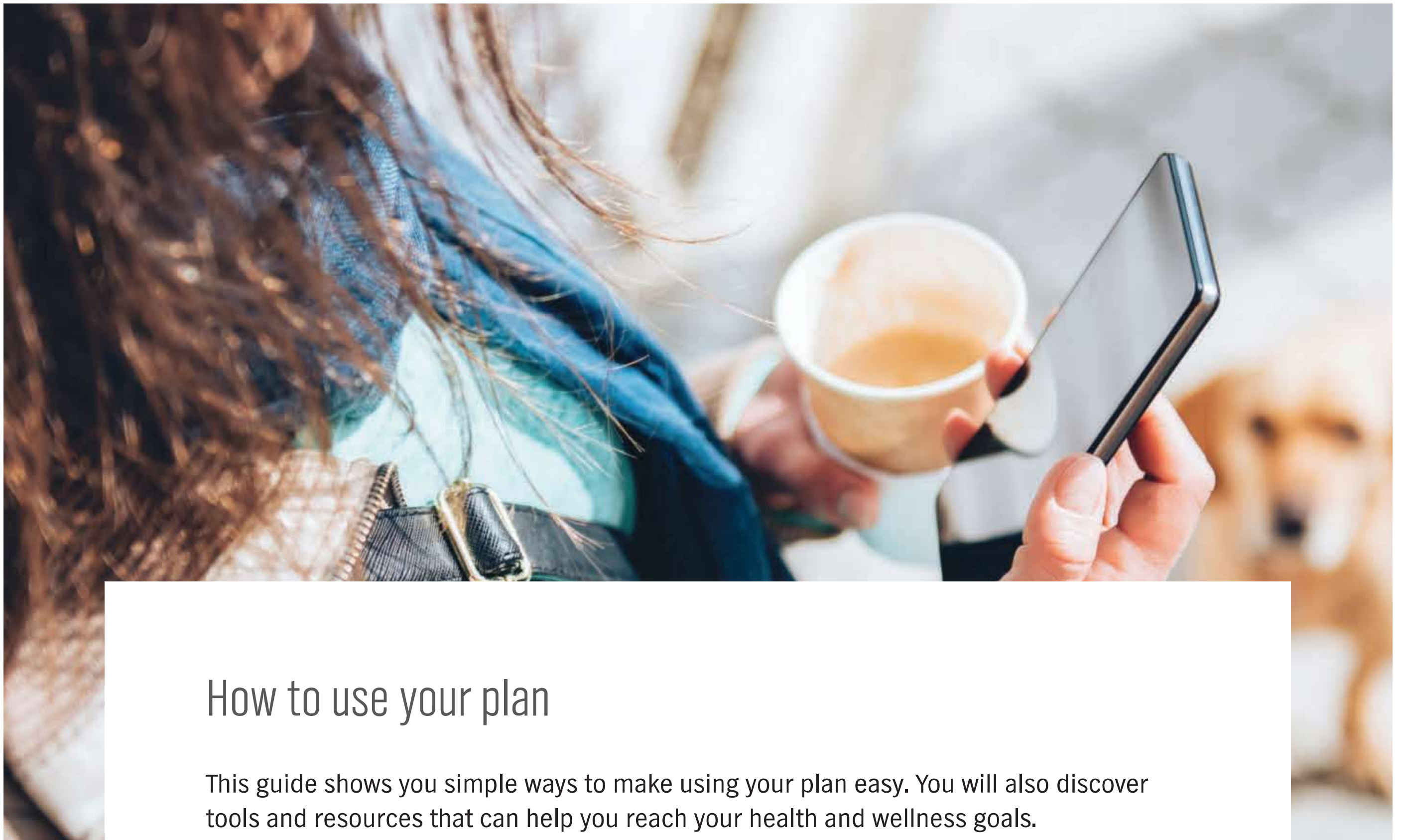
Once you are a member, you can check the price of a drug at different pharmacies at **empireblue.com** and see if there are lower-cost drugs available..

	Drug type	Cost
Tier 1	Preferred generic	$
Tier 2	Preferred brand name and newer, more expensive generic drugs	$$
Tier 3	Nonpreferred brand name and generic drugs	$$$

Ways to save money on medicine

- Use home delivery for medicines you take on a regular basis.
- Find a pharmacy in your plan's network.
- Talk to your doctor about generic medicines.
- See if an over-the-counter option is available.

Using your plan



How to use your plan

This guide shows you simple ways to make using your plan easy. You will also discover tools and resources that can help you reach your health and wellness goals.

How to use your plan

Use your ID card from your phone

Quickly access your ID card on your phone by using the **Sydney Health** mobile app or logging in at **empireblue.com.** Your digital ID card works the same as a paper one. You can share it with your doctor or pharmacy by printing a copy anytime you need one, or emailing or faxing it from your computer or mobile device. You also can download your ID card for quicker access.

Register for online tools and resources

Accessing your health plan on your mobile phone or computer makes it more convenient to manage your plan. Register on the **Sydney Health** mobile app and **empireblue.com** to receive personalized information about your health plan. You can also:

- Quickly access your digital ID card.
- Assess your symptoms at no cost, and get personalized information about a diagnosis, including over-the-counter medicine to take, and recovery time.
- Text with a board-certified doctor at no extra cost,[1] discuss treatment options, and order prescriptions.
- Have a video chat with a doctor.
- Find a doctor and estimate your costs before you receive care.
- Look at your prescription drug benefits, check the price of a drug, and find a pharmacy near you that's in your plan's network.
- View your claims, see what's covered, and what you may owe for care.
- Find support managing your health conditions and tracking your goals.
- Update your email and communication preferences.

1 Pricing based on $0 copay benefit eligibility offered through your plan.

How to use your plan

Find a doctor in your plan

The right doctor can make all the difference. Choosing a doctor who is in your plan's network can save you money. Your plan includes a broad selection of high-quality doctors. If you decide to receive care from doctors outside the plan's network, it will cost you more and your care might not be covered.

To find a doctor in your plan's network, use the **Find Care** tool on the **Sydney Health** mobile app or at **empireblue.com.** You can search for doctors, hospitals, and other healthcare professionals. You can also use the tool to search for high-quality, low-cost labs in your plan's network.

Schedule a checkup

Preventive care, such as regular checkups and screenings, can help you avoid health issues in the future. Your plan covers these services at little or no extra cost when you see a doctor in your plan's network:

- Yearly physical
- Well-child visits
- Flu shot
- Routine shots
- Screenings and tests

Check your plan details on the **Sydney Health** mobile app or **empireblue.com/find-care** to confirm what preventive care is covered.

How to use your plan

Travel with peace of mind

Your health plan goes with you when you're away from home and need care immediately. The BlueCard® program gives you access to services across the country. This includes 93% of doctors and 96% of hospitals in the U.S.[1] If you're traveling out of the country, you can receive care through the Blue Cross Blue Shield Global® Core program. It gives you access to doctors and hospitals in more than 190 countries and territories around the world.[2]

If you need care in the U.S. go to **empireblue.com.** When you're outside the U.S., visit **bcbsglobalcore.com** or download the BCBS Global Core mobile app. You also can call Blue Cross Blue Shield Global Core 24/7 at 011-800-810-BLUE (2583) or call collect by dialing 0170 and telling the operator you want to call 011-804-673-1177.

If you have questions about travel benefits, call the Member Services number on your ID card before you leave home.

Access care from home in a way that works for you

- Assess your symptoms online at no cost. Answer questions through the **Sydney Health** intuitive Symptom Checker. It uses the information you provide to narrow down millions of medical data points and assess your specific symptoms before you visit a doctor.
- Text with a board-certified doctor at no extra cost.[3] **Sydney Health** can link you directly to doctors for virtual text visits. During your appointment, the doctor can evaluate your symptoms, discuss your treatment options, and order prescriptions, if you need them.
- Have a video chat with a doctor. You can also use **Sydney Health** to connect with a board-certified doctor through video visits.
- See a doctor from home. Go to **livehealthonline.com** or download the **LiveHealth Online** mobile app to begin.

Where to go for care when you need it now

When it is an emergency, call 911 or go to the nearest emergency room.
If you need nonemergency care right away:

- Check to see if your primary care doctor can see you.
- Search for nearby urgent care to avoid costly emergency room visits and long wait times.
- See a doctor anytime using LiveHealth Online from your mobile device or computer.
- Call 24/7 NurseLine and receive helpful advice from a registered nurse.

1 Internal data, 2019.
2 GeoBlue website, *More than 20 years as a leader in international healthcare* (accessed May 2021): about.geo-blue.com.
3 Pricing based on $0 copay benefit eligibility offered through your plan.
LiveHealth Online is the trade name of Health Management Corporation.

Make the most of your pharmacy benefits

You can manage your prescriptions and costs at **empireblue.com.** Log in and explore the following ways to save:

1. **Search the drug list.** Find out if your medications are covered and which tier they are in. Lower-cost brand-name drugs and generics are usually in Tiers 1 and 2. You will save the most money when you use Tier 1 drugs.
2. **Price a medication.** See how much a medicine costs. You can compare retail drug costs at local pharmacies and see the price of generic options. Results will include the cost of up to a 90-day supply and home delivery pricing.
3. **Check if there are generic options.** If you're taking a brand-name drug, you can find a list of generic options that cost less, or ask your doctor.
4. **Most specialty drugs are covered if you need them.** Specialty drugs are for people with serious health issues. They come in different forms, such as pills or liquids. There are drugs that need to be injected, inhaled, or infused. They often need special storage and handling and may be given to you by a doctor or nurse. If you have a complex health condition that requires specialty drugs for your treatment you can receive them through IngenioRx Specialty Pharmacy. Call the Pharmacy Member Services phone number on your ID card for help.
5. **Choose a pharmacy that's in your plan.** You have many retail pharmacies from which to choose. Use a pharmacy that is in your plan to avoid paying full price. To find a pharmacy in your plan, visit **empireblue.com/pharmacyinformation/rxnetworks.html** and choose your network list. Your plan uses the **Base Network** list of pharmacies.
6. **Save time with home delivery.** If you take medicines regularly or need them on a long-term basis, you can save time with home delivery. You may also save money. You can receive a 90-day supply of your drugs delivered to your door. Maintenance medicines can vary in amounts. Once you're a member, visit **empireblue.com** to sign up.

For questions about your pharmacy benefits, call the Pharmacy Member Services phone number on your member ID card, 24/7.

For more information, go to **empireblue.com/FAQs** and select your state, then **Pharmacy.**

Plan extras that support your health

For details, register on the **Sydney Health** mobile app or at **empireblue.com.**

Your plan comes with great tools and programs to help you reach your health goals and save money on health products and services that may come at no extra cost. For detailed information, register on the Sydney Health mobile app or at **empireblue.com.**

Apps

Discover a powerful and more personalized health app. Access your benefits and wellness tools to improve your overall health with the **Sydney Health** app. The mobile app works with you by guiding you to better overall health — and works for you by bringing your benefits and health information together in one convenient place. **Sydney Health** has everything you need to know about your benefits to make the most of them while taking care of your health.

Working with you:

- Reminding you about important preventive care needs.
- Planning and tracking your health goals, fitness, and rewards.
- Guiding you with insights based on your history and changing health needs.
- Empowering you with personalized tools to find and compare healthcare providers and check costs.

Working for you:

- **Symptom Checker** — Answer questions through the **Sydney Health** intuitive Symptom Checker. It uses the information you provide to narrow down millions of medical data points and assess your specific symptoms before you visit a doctor.
- **Virtual text visits** — **Sydney Health** can link you directly to board-certified doctors for virtual text visits at no extra cost.* During your appointment, the doctor can evaluate your symptoms, discuss your treatment options, and order prescriptions, if you need them.
- **Virtual video visits** — You can also use **Sydney Health** to connect with a board-certified doctor through video visits.

Are you looking for healthy advice?

Follow our **Better Care Blog (empireblue.com/blog/)** for helpful information about health benefits, living healthy, and the latest member news.

* Pricing based on $0 copay benefit eligibility offered through your plan.

Plan extras that support your health

For details, register on the **Sydney Health** mobile app or at **empireblue.com.**

Empire Skill — Our Empire Skill for Alexa is a voice-activated assistant for your health plan. Receive answers to your healthcare questions — hands-free by enabling the Empire Skill. It works through any Alexa-enabled device, such as an Amazon Echo, or on your mobile device using the Amazon Alexa app.

- Ask for your digital member ID card.
- Access your health savings account (HSA) or health reimbursement account (HRA) balance, if you have one.
- Check your progress toward meeting your medical plan's deductible and out-of-pocket maximum.
- Refill, renew, and check the order status of any home delivery prescriptions.

If you do not have the Amazon Alexa app, download it from Google Play™ or the App Store®.

Medical guidance

24/7 NurseLine — You can connect with a registered nurse who will answer your health questions wherever you are — anytime, day or night. They can help you decide where to go for care and find doctors and other healthcare professionals in your area. Call **800-337-4770.**

Empire Health Guides — Highly trained Empire associates are like personal support guides who can help you with all your healthcare needs. They can help you connect with the right resources, stay on top of the screenings and tests you need, and find doctors. Reach a health guide by calling the number on your member ID card. You also can go to **empireblue.com** to send a secure email or chat with them online.

Case Management — If you're coming home after surgery or have a serious health condition, a nurse care manager can help answer your questions about your follow-up care, medicines and treatment options, coordinate benefits for home therapy or medical supplies, and find community resources to help you. Your nurse care manager will call you, but you also can call the Member Services number on your ID card.

ConditionCare — Receive support from a dedicated nurse team to manage ongoing conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, or heart failure. Work with dietitians, health educators, and pharmacists who can help you learn about your condition and manage your health.

Future Moms — This program can help you take care of yourself and your baby before, during, and after pregnancy. You can talk to registered nurses 24/7 about your pregnancy and newborn care. You also have access to dietitians and social workers, as needed.

Shopper program for imaging services — The cost of imaging services like X-rays, ultrasounds, MRIs, and CT scans can range from $300 to $3,000.* A higher price doesn't always mean better care. If your doctor lets us know you need imaging, we will shop around to find the best value. You also can call us directly at 888-953-6703. If we find an option that costs less, we will let you know. The choice of where you go is always up to you.

*Source: AIM Specialty Health®, internal claims cost analysis.

Plan extras that support your health

For details, register on the **Sydney Health** mobile app or at **empireblue.com.**

Healthy living

MyHealth Advantage — There is no cost for this service, and it can help you stay healthy and save money. You will receive reminders when you need to refill a prescription or have a checkup, test, or exam. You will also receive a personalized and confidential MyHealth Note in the mail or on the **Sydney Health** mobile app if we see something that might help you.

SpecialOffers — With SpecialOffers, you can receive discounts on products and services that help promote better health and well-being.

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Your guide to earning rewards with Wellbeing Solutions

Your whole health matters. That's why you have Wellbeing Solutions, a suite of programs to help you with your everyday health and well-being. You receive extra guidance and support in managing your health, plus you can earn monetary rewards.

Earn up to **$1,100 in rewards**

Empire Health Rewards[1] offers you and your covered spouse or partner up to $1,100 in rewards for taking part in employer-sponsored health and wellness programs. You will receive your rewards through digital gift cards.[2] You can see the status of your progress on empireblue.com or download the free Sydney Health mobile app.

Includes

Well-being Coach[3]

Well-being Coach offers multiple options to help you meet your well-being goals. Our digital coaching app offers personalized 24/7 support on the go, whenever you need it. Well-being Coach combines smart technology and proven behavioral therapy techniques to help you maintain a healthy weight or quit tobacco. You can also receive additional help on well-being topics like nutrition, activity, mindfulness and sleep. Well-being Coach is powered by Lark and accessible from the Sydney Health app.

If you prefer a helping hand or require additional support meeting your health goals, Well-being Coach gives you access to a certified Health Coach by phone. You and your coach will identify habits you want to change and develop custom action plans to achieve your health goals. No matter how you connect, you can earn rewards with Well-being Coach.

Rewards you can earn (up to $1,100 total)

Earn up to **$300** for either Well-being Coach or ConditionCare[4]

ConditionCare reward

If you have a chronic condition like asthma or diabetes, you can receive one-on-one help from a health care professional through ConditionCare. You'll learn better ways to manage your health and reach your health goals.

Earn up to $300 for participating in a nurse-centric program focused on helping members with high-risk conditions:

- **$100** for participating in program
- **$200** for completing program

To find out more about the program or to sign up, call the Member Services number on your ID card.

or

Well-being Coach Telephonic reward

Whether it's time to quit smoking, push past a weight-loss plateau, you can receive the lifestyle coaching you need from a live health coach.

Earn up to $300 for receiving one-on-one support through live coaching for high-risk conditions of tobacco cessation or weight management:

- **$100** for participating in program
- **$200** for completing program

Each well-being coach is specially trained to help you meet your health goals. You can find Well-being Coach on empireblue.com or the Sydney Health app. You can also call 1-833-985-8464 to speak directly with a Health Coach.

Gym Membership Reimbursement **- up to $400**

Putting a lot of hard work and sweat in at the gym is made even more worthwhile with a gym reimbursement. Members 18 years and older can get reimbursed up to $400 for meeting the minimum gym visit requirement (35 visits minimum for every six month period, $200 twice annually) at a qualifying fitness center.[5]

Work out 35 times in each six-month period within your benefit plan year at a qualifying fitness center, track your workout sessions and send in the completed required forms. To find out more and download forms, log in to empireblue.com or the Sydney Health app and visit the My Health Dashboard, then the Programs area.

Future Moms reward **- up to $200**

Moms-to-be can receive support and earn rewards. Registered nurses help them make healthy choices and follow the doctor's plan of care for a safe delivery and healthy baby.

- Receive $100 for completing an initial maternity assessment
- $50 for completing interim assessment
- $50 for completing post-birth assessment

To find out more about the program or to sign up, call the Member Services number on your ID card.

Flu shot and wellness visit reward **- up to $50**

For extra motivation to stay healthy, you can earn $50 in rewards for receiving a claims-based annual preventive wellness exam and flu shot.

Visit your primary care doctor's office for your wellness exam. You can also receive a flu shot at your doctor's office, or at a pharmacy or retail clinic. Your wellness exam or flu shot do not need to be completed in any particular order or together. Be sure to submit the claims to Empire or ask your doctor or other provider to submit them to Empire for you.[6]

My Health Rewards Activities **- up to $150**

Keep up healthy habits by tracking your activity through empireblue.com, Sydney Health or the Well-being Coach app. You can also track rewards activities through a variety of devices, such as Apple Health Kit, Google Health, and more. Go to the Help section of Sydney Health for a full list of supported devices.

Sydney Health Activities

- Login to website or mobile app - 10 points / yearly
- Connect a tracking device - 15 points / yearly
- Complete the WebMD Health Risk Assessment - 75 points / yearly
- Read five articles or watch five videos - 25 points / yearly (5 points earned at a time)
- Article/video topics include: exercise, healthy eating, sleep, family health, mind & body, what's new, trending, and more
- Set an action plan - 10 points / once per quarter
- Action plans include: Eat Healthy, Achieve a Healthy Weight, Get Active, Increase Energy, Reduce Stress and Sleep Better
- Complete an action plan - 100 points / once per quarter
- Track steps
    - Average 2,000 steps a day - 2 points / monthly
    - Average 5,000 steps a day - 5 points / monthly
    - Average 7,500 steps a day - 10 points / monthly

Well-being Coach Activities

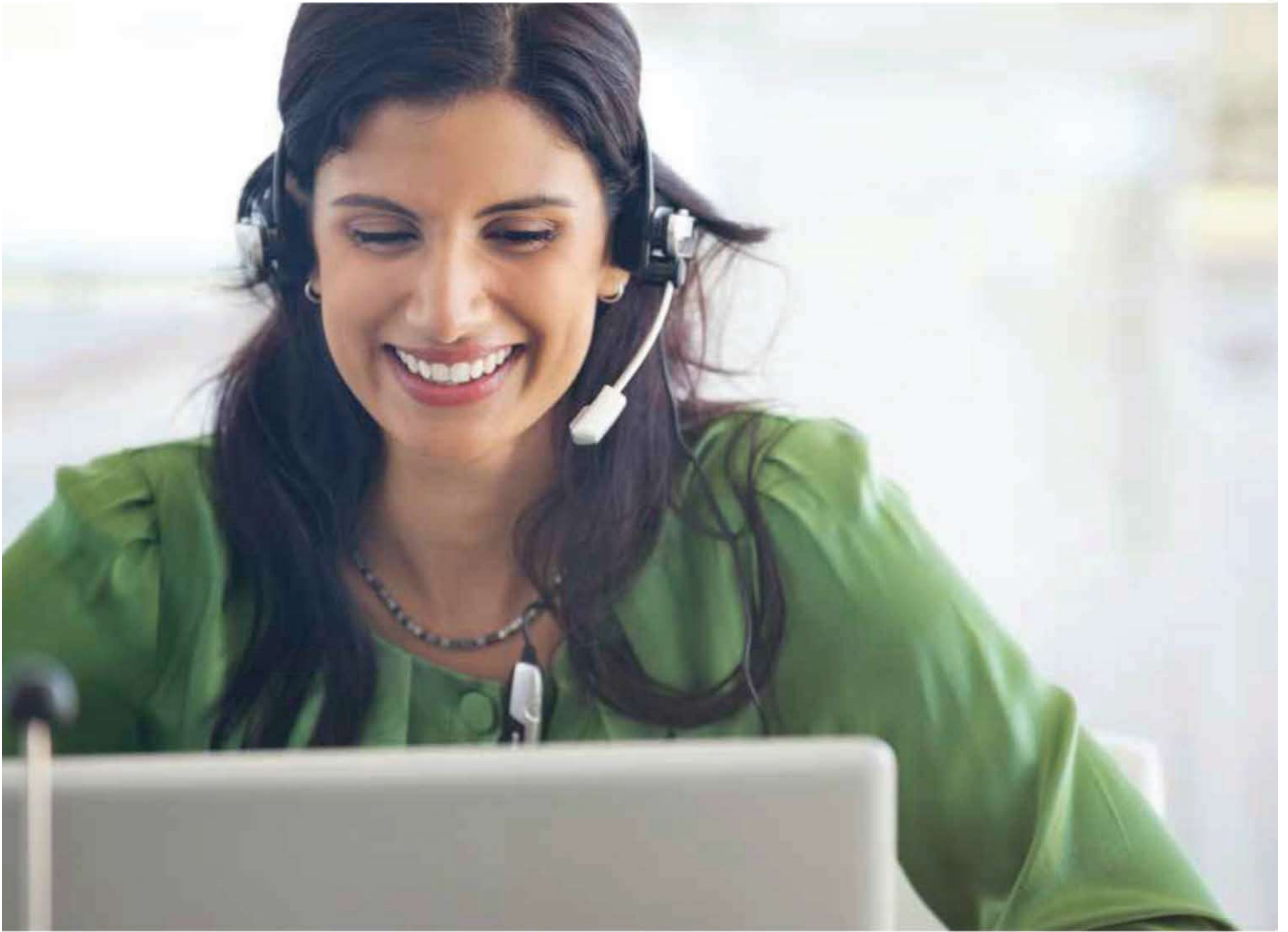
- First completed Mission daily check-in - 10 points
- Achieve 15 completed Mission daily check-ins during the first three months - 15 points
- Achieve 25 completed Mission daily check-ins during the second three months - 25 points
- Achieve 25 completed Mission daily check-ins during third three months - 25 points
- Achieve 25 completed Mission daily check-ins during fourth three months - 25 points

You will receive a reward payout when you reach the milestones of 100, 200 and 300 points. Each milestone equals $50.

Example: First, you receive a reward payout when you reach the 100 point milestone. Then, your points balance resets to zero. To reach the next milestone, you will need to earn 200 points. When you reach this 200 point milestone, you receive a reward payout and your points will reset again to zero. To receive the final reward payout, you will need to earn another 300 points.

YOU DESERVE GOOD HEALTH

START TODAY. REGISTER AT EMPIREBLUE.COM OR DOWNLOAD THE FREE SYDNEY HEALTH MOBILE APP.



If you have any questions, call the Member Services number on your ID card.

I Empire Health Rewards eligibility applies to only employees and their spouse/domestic partner. Member must be active on the plan and activity must take place during the plan effective year.
2 Employees can follow their progress and rewards earned through empireblue.com or Sydney Health[SM]. Sydney Health serves as our fully integrated digital platform, fostering the most personalized, optimal experience possible. Sydney Health is offered through an arrangement with CareMarket, Inc. Sydney and Sydney Health are trademarks of CareMarket, Inc. @2020-2021.
3 Well-being Coach Digital is powered by the Lark platform and accessible to the member via Sydney Health.
4 You can achieve either the Well-being Coach reward or the ConditionCare reward.
5 Members ages 18 and over, including subscribers' adult children ages 18 and older, are eligible for gym reimbursement. Gym reimbursement is paid by check. Payout is per member per benefit year. This program is designed to help you make healthy, safe and small changes to your lifestyle. Before taking part in this program, talk to your doctor or health care provider- especially if you are pregnant or have an injury or medical condition. This program may not be right for everyone.
6 You must complete an annual wellness exam and flu shot during your employer group's plan year. Once we receive an Empire claim for both an annual wellness examination and a claim for an annual flu shot, you are eligible for the reward. It may take up to 75 business days from the day the second of the two preventive care activities is completed for both rewards to be disbursed to your rewards account.

The amount of rewards loaded on your digital gift card may be considered income to you and subject to state and federal taxes in the tax year it is paid. We recommend that you consult a tax expert with any questions regarding your tax obligations.

Health and wellness programs are not covered services under your group's medical insurance policy, but are separate components of your group health plan which are not guaranteed under your insurance Certificate and could be discontinued at any time. If it is unreasonably difficult due to a medical condition for you to achieve the standards (if any) for a reward under these programs, or if it is medically inadvisable for you to attempt to achieve the standards for the reward, we will work with you to develop another way to qualify for the reward.

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc.. dba Empire BlueCross BlueShield. Independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Save time and money on prescriptions with home delivery

Getting your prescription drugs doesn't have to be a drag. We help make it easier and more convenient for you to get the medicines you need.

Home delivery: Skip the drugstore line

If you take prescription medicines on a regular basis, you can get up to a 90-day supply delivered to your home.[1] And depending on your plan, you may save on copays. That's because a 90-day supply of many drugs usually costs less than three 30-day refills.

Missing even one dose of a medicine that treats long-term conditions like high blood pressure or diabetes may lead to serious health problems and higher health care costs. That's why home delivery is a great way to make sure you get your prescription refills when you need them.

Standard shipping is free, and you can set up automatic renewals to get your next three-month supply sent to you before the refill date.

How to get started with home delivery

Getting set up for home delivery is easy. Just call the **Pharmacy Member Services** phone number on the back of your health plan ID card. You can also mail in your order with our order form found on **empireblue.com**. Choose **Individual & Family**, then **Forms**.

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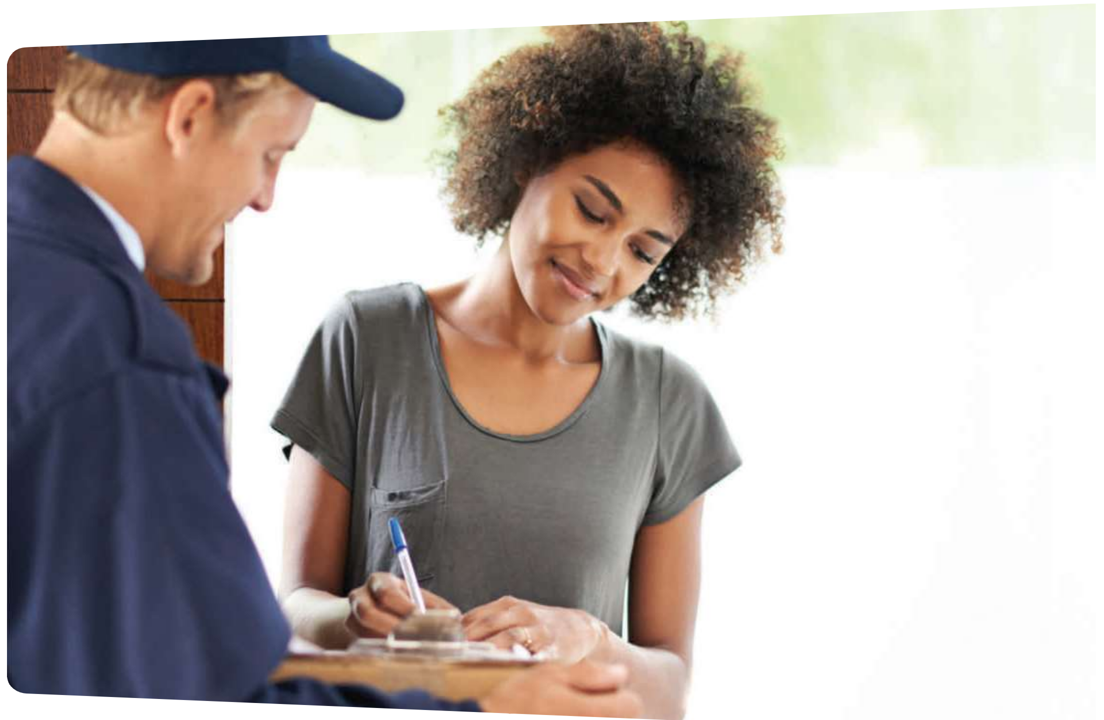
Need help?

Call the home delivery pharmacy at 1-833-203-1739 or call the Pharmacy Member Services phone number on the back of your health plan ID card.

You may want to ask your doctor for a 30-day prescription, which you can get filled at your regular pharmacy, to make sure you have enough medicine to last until you get your first home delivery prescription.

Here are a few more important things to know

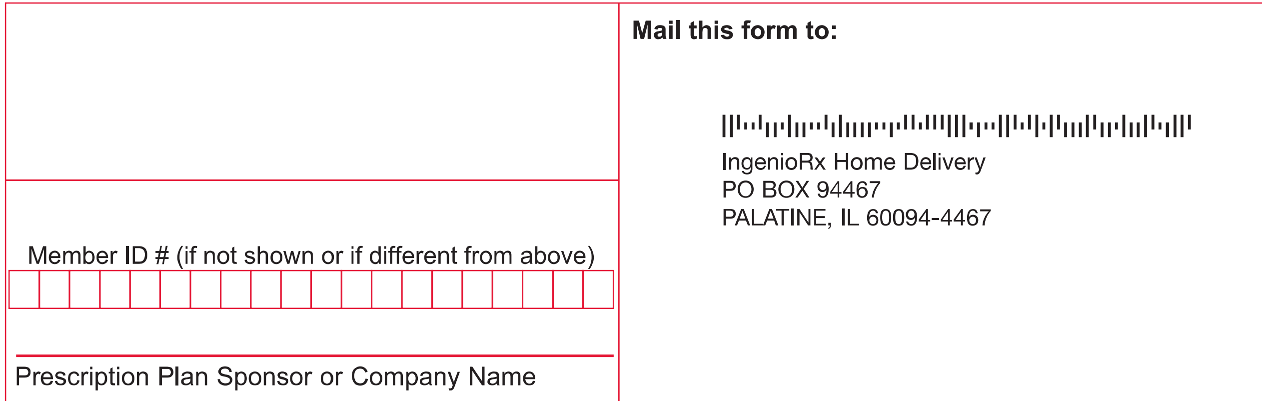
- Using our mobile app, Sydney Health, or empireblue.com to switch to home delivery is only available if your Empire pharmacy plan benefits include mandatory home delivery, opt-out home delivery or Rx Maintenance 90. If you have optional home delivery, call the **Pharmacy Member Services** phone number on the back of your health plan ID card, or complete and mail the *Home Delivery Order Form* to transfer your prescriptions from your retail pharmacy to home-delivery.
- If your doctor prescribes a brand-name drug, your pharmacy plan may require the home delivery pharmacy to send a generic version instead.
- All prescriptions and refills, including those sent by your doctor, will be filled as soon as the home delivery pharmacy gets them. In most cases, your first order will arrive within two weeks. After that, orders will arrive within one week.
- If you need your medicine sooner, you can call the home delivery pharmacy and ask for overnight delivery. You'll be charged extra for the faster shipping.
- With some drugs, you may need to sign to accept delivery.[2]



1 Supplies vary based on your pharmacy plan design.
2 Drugs that are defined as controlled substances are highly regulated, which requires the home delivery pharmacy to follow special rules for filling these prescriptions.

Services provided by Empire HealthChoice HMO, Inc., Empire HealthChoice Assurance, Inc., and/or HealthPlus HP, LLC. Independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

IngenioRx Mail Service Order Form



Instructions:
Please use **blue or black ink** and **print in capital letters.** Fill in **both sides** of this form.

New Prescriptions – Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills – Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online or by phone at the website/phone number on your member ID card.

A Shipping Address. To ship to an address different from the one printed above, enter the changes here.

Last Name First Name MI Suffix (JR, SR)

Street Address Apt./Suite #

○ **Use shipping address for this order only.**

City State ZIP Code

Daytime Phone #: - - Evening Phone #: - -

B Refills. To order mail service refills, enter your prescription number(s) here.

1)______ 2)______ 3)______ 4)______

5)______ 6)______ 7)______ 8)______

Log in to check order status and access personalized information about your prescription benefits. When getting a new prescription, be sure to ask your doctor to write it for the maximum amount allowed by your plan, usually a 90-day supply. Make sure your doctor SIGNS and DATES all new prescriptions. We want to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

We may package all of these prescriptions together unless you tell us not to.

Please fold here

Please fold here

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C Tell us about the people ordering prescriptions. If there are more than two people, please complete another form.

First person with a refill or new prescription. ◯ Spanish forms and labels

LAST NAME | FIRST NAME | M | Suffix (JR,SR)

NICKNAME | Gender: ◯ M ◯ F | Date of birth: MM-DD-YYYY

E-mail address: ______ Date new prescription written: ______

Doctor's last name ______ Doctor's first name ______ Doctor's phone # ______

Tell us about new health information for 1st person if never provided or if changed.

Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: ______

Medical conditions: ◯ Arthritis ◯ Asthma ◯ Diabetes ◯ Acid reflux ◯ Glaucoma ◯ Heart problem ◯ High blood pressure ◯ High cholesterol ◯ Migraine ◯ Osteoporosis ◯ Prostate issues ◯ Thyroid ◯ Other: ______

Second person with a refill or new prescription. ◯ Spanish forms and labels

LAST NAME | FIRST NAME | M | Suffix (JR,SR)

NICKNAME | Gender: ◯ M ◯ F | Date of birth: MM-DD-YYYY

E-mail address: ______ Date new prescription written: ______

Doctor's last name ______ Doctor's first name ______ Doctor's phone # ______

Tell us about new health information for 2nd person if never provided or if changed.

Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: ______

Medical conditions: ◯ Arthritis ◯ Asthma ◯ Diabetes ◯ Acid reflux ◯ Glaucoma ◯ Heart problem ◯ High blood pressure ◯ High cholesterol ◯ Migraine ◯ Osteoporosis ◯ Prostate issues ◯ Thyroid ◯ Other: ______

Please fold here

D Special instructions: ______

E How would you like to pay for this order? (If your copay is $0, you do not need to provide payment information.)

◯ **Electronic check.** Pay from your bank account. (You must first register online or call Customer Care.)

Please fold here

◯ **Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)

◯ Use your card on file.

◯ Use a new card or update your card's expiration date.

CARD NUMBER | Exp. Date MMYY

Credit card holder signature/Date ______

◯ **Check or money order.** Amount: $ ____ . __

- Make check/money order out to IngenioRx Home Delivery.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to $40.

Payment for balance due and future orders: If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

◯ Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

Regular delivery is free and takes up to 5 days after your order is processed.
If you want faster delivery, choose:

◯ **2nd business day ($17)**
◯ **Next business day ($23)**

Faster delivery can only be sent to a street address, not a PO Box

Expected processing time from receipt of this form:
- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor

(Charges subject to change)

49-MOF 0316 INGENIORX

Instructions for completing the *Member Authorization Form*

An Anthem Company

If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page one of the form.

Part A: Member information

This section applies to the member who is asking for the release of his or her information to another person or company.

1. Print your last name, first name, and middle initial.
2. Write your date of birth in this format: mm/dd/yyyy. (If you were born on October 5, 1960, you would write 10/05/1960.)
3. Write your full street address, city, state, and ZIP code.
4. Write your daytime phone number (including area code.)
5. **Identification number**
   You will find this number on your member identification card.
6. **Group number**
   You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

Part B: Person or company who will receive this information

7. Check the box that applies to you. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
8. If you check "Other," give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

Part C: Information that can be released

This section tells us what information you would like us to release: all or just some.

9. For "all of your information," check the first box.
10. For "limited information," check the second box and the boxes that apply to you.
11. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

Member Authorization Form

Empire BlueCross BlueShield
An Anthem Company

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name (1)	Member first name	Middle initial	Member date of birth (2)
Member street address (3)	City	State	ZIP code
Daytime telephone number (with area code) (4)	Identification number (see identification card) (5)	Group number (see identification card) (6)	

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name.

☐ **My spouse** (enter first and last name) (7)	☐ **My parents** (if you are over 18 – enter first and last name[s])
☐ **My domestic partner** (enter first and last name)	☐ **My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
☐ **My adult children** (enter first and last name[s])	☐ **Other** (enter first and last name [if you have it], name of company, and how it's related to you) (8)

Part C: Information that can be released

I allow the following information to be used or released by Empire BlueCross BlueShield (Empire) on my behalf (check only one box):

(9) ☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

(10) ☐ **Only limited information** may be released (check all boxes below that apply to you).

☐ Appeal	☐ Doctor and hospital	☐ Referral
☐ Benefits and coverage	☐ Eligibility and enrollment	☐ Treatment
☐ Billing	☐ Financial	☐ Dental
☐ Claims and payment	☐ Medical records	☐ Vision
☐ Diagnosis (name of illness or condition) and procedure (treatment)	☐ Pre-certification and pre-authorization (for treatment approvals)	☐ Pharmacy
		☐ Other: ______

I also approve the release of the following types of sensitive information by Empire (check all boxes that apply to you):

(11) ☐ **All sensitive information**

OR

☐ **Just information about topics checked below**

☐ Abortion	☐ Genetic testing	☐ Mental health
☐ Abuse (sexual/physical/mental)	☐ HIV or AIDS	☐ Sexually transmitted illness
☐ Alcohol/substance abuse*	☐ Maternity	☐ Other: ______

* I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

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Please read the following for help completing page two of the form.

Part D: Purpose of this approval

This section tells us the reason you've asked for the release of your information.

❶ Check the first box to let us know to give out this information as shown on this form.

❷ Check the second box for a specific reason. An example might be to settle a life insurance claim.

Part E: Date your approval expires

You have two choices of when you would like this approval to end.

❸ Check the first box for the standard one year that it will end.

❹ Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

Part F: Review and approval

❺ **Sign your name and put the date on the form.** Your name and signature ***must*** match the information in Part A.

❻ **If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:**

- You must complete the Designated Legal Representative/Guardian section.
- You must also provide us with a copy of the legal document showing that you are approved and include it with this form.

Part D: Purpose of this approval

❶ ☐ To give out the information as shown on this form.
OR
❷ ☐ For this reason(s): ____________________

Part E: Date your approval expires

If this document was not already withdrawn, this approval will end on the earliest of the following dates:
❸ ☐ One year from the signature date in Part F.
OR
❹ ☐ Earlier than one year and upon the date, event or condition described below:
____

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow Empire to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Empire does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Empire. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature ❺ X	Date

Designated Legal Representative/Guardian ❻

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)		Legal relationship to member	
Legal representative street address	City	State	ZIP code
Signature X			Date

Please return the completed form to:
Empire BlueCross BlueShield
P.O. Box 1407 Church Street Station
New York, NY 10008–1407

Be sure to keep a copy of this form for your records.

For recipient of substance abuse information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For internal use only:	Inquiry tracking number

2 of 2

Examples of legal documents:

- **Health Care, General or Durable Power of Attorney.** This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- **Legal Guardianship.** This is when the court appoints someone to care for another person.
- **Conservatorship.** This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- **Executor of estate.** This type of document would be used when the person who is being represented has died.

Member Authorization Form

An Anthem Company

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name	Member first name	Middle initial	Member date of birth
Member street address	City	State	ZIP code

Daytime telephone number (with area code)	Identification number (see identification card)	Group number (see identification card)

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name.

☐ **My spouse** (enter first and last name)	☐ **My parents** (if you are over 18 – enter first and last name[s])
☐ **My domestic partner** (enter first and last name)	☐ **My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
☐ **My adult children** (enter first and last name[s])	☐ **Other** (enter first and last name [if you have it], name of company, and how it's related to you)

Part C: Information that can be released

I allow the following information to be used or released by Empire BlueCross BlueShield (Empire) on my behalf (check only one box):

☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

☐ Appeal
☐ Benefits and coverage
☐ Billing
☐ Claims and payment
☐ Diagnosis (name of illness or condition) and procedure (treatment)
☐ Doctor and hospital
☐ Eligibility and enrollment
☐ Financial
☐ Medical records
☐ Pre-certification and pre-authorization (for treatment approvals)
☐ Referral
☐ Treatment
☐ Dental
☐ Vision
☐ Pharmacy
☐ Other: ____________________

I also approve the release of the following types of sensitive information by Empire (check all boxes that apply to you):

☐ **All sensitive information**

OR

☐ **Just information about topics checked below**

☐ Abortion
☐ Abuse (sexual/physical/mental)
☐ Alcohol/substance abuse*
☐ Genetic testing
☐ HIV or AIDS
☐ Maternity
☐ Mental health
☐ Sexually transmitted illness
☐ Other: ____________________

*I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Part D: Purpose of this approval

☐ To give out the information as shown on this form.
OR
☐ For this reason(s): ______________________________

Part E: Date your approval expires

If this document was not already withdrawn, this approval will end on the earliest of the following dates:
☐ One year from the signature date in Part F.
OR
☐ Earlier than one year and upon the date, event or condition described below:
____

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow Empire to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Empire does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Empire. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature	Date
X	

Designated Legal Representative/Guardian

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member

Legal representative street address	City	State	ZIP code

Signature	Date
X	

Please return the completed form to:
Empire BlueCross BlueShield
P.O. Box 1407 Church Street Station
New York, NY 10008–1407

Be sure to keep a copy of this form for your records.

For recipient of substance abuse information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For internal use only:	Inquiry tracking number

Empire BlueCross
Anthem Life & Disability Insurance Company
Large Group Member Enrollment/Change Form

An Anthem Company

Anthem Life & Disability Insurance Company underwrites Life and Disability products. Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc. underwrite medical, dental, vision, group accident, specified disease and hospital indemnity insurance products.

Thank you for choosing Empire BlueCross BlueShield (Empire) and Anthem Life & Disability Insurance Company (Anthem Life).
So that we may quickly and accurately process your enrollment, please complete in full and sign in section 8.

Section 1: Reason for enrollment/change — Please complete section A, B or C.

A. New enrollment/addition — Choose only one reason in bold.

☐ **New hire** – Must indicate start date of full-time employment in section 9. Leave *Date of change* field blank. Date of change: ______ (MMDDYY)
☐ **Open enrollment** – Leave *Date of change* field blank.
☐ **Status change** – Select only one.
☐ Marriage ☐ Newborn ☐ Adoption ☐ Retirement ☐ Medicare eligible For ***Medicare eligible*** only, answer the following questions:
Eligibility criteria – Select only one .... ☐ Age 65+ ☐ Disability ☐ ESRD: Onset date: ______
Active employee? .... ☐ Yes ☐ No
Electing company coverage as primary coverage? .... ☐ Yes ☐ No
Electing Medicare-related coverage as primary coverage? ... ☐ Yes ☐ No
(If company size is under 20 employees and end-stage renal disease does not apply, you must choose this option)
☐ **Age 29 Adult Dependent Election** – Must complete section 4.
☐ **Original COBRA/NYS Continuation of coverage:** ______ (MMDDYY)
Nature of COBRA/NYS event: ______
☐ **Loss of Coverage** – Must indicate last day covered in section 6.
☐ **Waive Life coverage**
☐ **Other:** ______

B. Change — Check all that apply. For all checked boxes below, please supply new information in sections 4 and 5.

☐ Name ☐ Primary Care Physician (PCP) (POS plans only) Date of change: ______ (MMDDYY)
☐ Address ☐ Managed Dental Primary Care Dentist (PCD) (If your company offers an Empire Dental plan)
☐ Change Life and/or Disability insurance classification from Class ________________ to Class ________________

C. Cancel coverage — Select only one.

Note: If you are canceling your own coverage, please have your employer fill out an *Employee Termination Form*. For other cancellations, please check the appropriate box below and enter the name in the Applicant and Family portion in section 5.

Spouse/Dependent ☐ Death ☐ Divorce ☐ Dependent no longer eligible Date of event: ______ (MMDDYY)
☐ Other: ______

Section 2: Benefits Selection

Medical insurance — Select only one plan type.

Large group plans (101+ eligibles)

☐ Empire EPO – (Copay/Deductible/Coinsurance)
☐ Empire EPO – (Copay)
☐ Empire PPO – (Copay/Deductible/Coinsurance)
☐ Empire PPO – (Copay)
☐ Empire PPO with HSA
☐ Empire PPO with HRA
☐ Empire EPO with HSA
☐ Empire EPO with HRA
☐ Empire EPO with HSA – (Copay)
☐ Empire EPO with HRA – (Copay)
☐ Empire EPO – (Deductible/Coinsurance)
☐ Empire PPO – (Deductible/Coinsurance)
☐ Empire EPO with HRA – (Deductible/Coinsurance)
☐ Empire PPO with HRA – (Deductible/Coinsurance)
☐ Empire Blue Access EPO – (Copay Plan)
☐ Empire Blue Access EPO – (Copay Design for 0% Coins Plans)
☐ Empire Blue Access EPO – (Copay w/Deductible)
☐ Empire Blue Access EPO – (Prism/Direct Connect/Deluxe)
☐ Empire Blue Access EPO with HRA – (Ded/Coins)
☐ Empire Blue Access EPO with HRA – (Ded/Coins w/Copays)
☐ Empire Blue Access EPO with HSA – (Ded/Coins)
Other: ____
☐ Empire Blue Access GEPO – (Copay Design)
☐ Empire Blue Access GEPO – (Copay Design for 0% Coins Plans)
☐ Empire Blue Access GEPO – (Copay w/Deductible)
☐ Empire Blue Access GEPO – (Prism/Direct Connect/Deluxe)
☐ Empire Blue Access GEPO with HRA – (Ded/Coins)
☐ Empire Blue Access GEPO with HRA – (Ded/Coins w/Copays)
☐ Empire Blue Access GEPO with HSA – (Ded/Coins)
☐ Empire Blue Access PPO – (Copay)
☐ Empire Blue Access PPO – (Copay Design for 0% Coins Plans)
☐ Empire Blue Access PPO – (Copay w/Deductible)
☐ Empire Blue Access PPO – (Copay/Deductible/Coinsurance)
☐ Empire Blue Access PPO – (Prism/Direct Connect/Deluxe)
☐ Empire Blue Access PPO with HRA – (Deductible/Coinsurance)
☐ Empire Blue Access PPO with HSA – (Deductible/Coinsurance)
☐ Empire Connection EPO – (Prism/Direct Connect/Deluxe)
☐ Empire Connection EPO – (Copay Design for 0% Coins Plans)
☐ Empire Connection EPO – (Copay Design)
☐ Empire Connection EPO – (Copay w/Deductible)
☐ Empire Connection GEPO – (Prism/Direct Connect/Deluxe)
☐ Empire Connection GEPO – (Copay Design for 0% Coins Plans)
☐ Empire Connection GEPO – (Copay)
☐ Empire Connection GEPO – (Copay w/Deductible)

Select only one medical coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Section 2: Benefits selection – Continued.

Dental insurance [1]

☐ Empire Dental Prime
☐ Empire Dental Complete
☐ Empire Dental Premium Care (PPO)
☐ Empire Dental XPO
☐ Empire Dental Consumer Choice PPO
☐ Empire Dental Essential Choice PPO
☐ Empire Dental Enhanced Choice PPO
☐ Empire Dental Essential Care (managed care)
☐ Empire Dental Enhanced Care PLUS (managed care)
☐ Empire Dental Enhanced Care (managed care)
☐ Empire Dental Comprehensive Care (managed care)

Select only one dental coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Vision insurance [2]

Blue View Vision℠ Select only one vision coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Flexible Spending Account (FSA)

☐ Healthcare FSA (excluded if you have an HSA plan) ☐ Limited-Purpose FSA for dental and vision services only (with an HSA plan)

Life and Disability coverage

☐ Basic Life
☐ Basic Life and Accidental Death and Dismemberment (AD&D)
☐ Basic Dependent Life
☐ Supplemental/Voluntary Life and AD&D . . . . $________________ (employee amount)
☐ Supplemental/Voluntary Dependent Life Spouse. . . . . . $________________ (spouse amount)
☐ Supplemental/Voluntary Dependent Life Child. . . . . $________________ (child amount)
☐ Voluntary Accidental Death and Dismemberment . . . . . $________________ (employee amount)
☐ Voluntary Accidental Death and Dismemberment Family Plan (Spouse and Child coverage)
☐ Voluntary Accidental Death and Dismemberment Spouse Only (no Child coverage)
☐ Voluntary Accidental Death and Dismemberment Child Only (no Spouse coverage)
☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income $________________	Occupation	Life and disability class no.

Beneficiary designation – Attach a separate sheet if necessary.

☐ Primary ☐ Contingent	Name of beneficiary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage
☐ Primary ☐ Contingent	Name of beneficiary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage
☐ Primary ☐ Contingent	Name of beneficiary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage
☐ Primary ☐ Contingent	Name of beneficiary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage

Total percentages must add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following.

Authorization

I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

In CA, NV, and WA, Spouse also includes your registered Domestic Partner.

Spouse signature X	Spouse name (print)	Date (MMDDYY)

1 If your company offers an Empire Dental plan.
2 If your company offers a Blue View Vision plan.

Section 3: Voluntary Accident, Specified Disease, and Hospital Indemnity Insurance

☐ Voluntary Accident Insurance – Coverage option: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one accident plan offered please select: ☐ Low Plan ☐ High Plan

☐ Voluntary Specified Disease Insurance – Coverage option: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Specified Disease plan offered please select: ☐ Low Plan ☐ High Plan
Have you smoked or used tobacco products in the last 12 months? ☐ No ☐ Yes, explain product used: ____________________

☐ Voluntary Hospital Indemnity Insurance – Coverage option: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Hospital Indemnity plan offered please select: ☐ Low Plan ☐ High Plan

If any person to be covered by a Specified Disease or Hospital Indemnity plan is a resident of CA, GA, NY or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY or CO, when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy or an employer sponsored health plan that provides essential health benefits? ☐ No ☐ Yes (Please note that if the response is No, such applicants are not eligible for coverage)

Will all applicants who reside in NY, when such coverage is to become effective, be enrolled under or have another application(s) pending for any other specified disease policy that is not being replaced in full by this coverage? **(Please note that if the response is Yes, such applicants may not be eligible for coverage)** ☐ No ☐ Yes

Applicants residing in NY: As of the date of this application, total number of specified diseases for which all applicants have specified disease coverage in force or have another application(s) pending for any other specified disease policy: Employee: ________ Spouse: ________ Child(ren): ________

List specific specified diseases for which all applicants have specified disease coverage in force or have another application(s) pending for any other specified disease policy (list applicable conditions):

Employee: ____________________

Spouse: ____________________

Child(ren): ____________________

Beneficiary designation – Attach a separate sheet if necessary.

☐ Primary ☐ Contingent	Name of beneficiary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage
☐ Primary ☐ Contingent	Name of beneficiary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage
☐ Primary ☐ Contingent	Name of beneficiary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage
☐ Primary ☐ Contingent	Name of beneficiary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage

Total percentages must add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Section 4: Applicant information

Last name		First name		M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Marital status ☐ Single ☐ Married	Marriage date (MMDDYY)	Primary phone no.	
Street address					Apt. no.
City				State	ZIP code
Occupation		Primary language			
Email address[2]					
Please provide a copy of the Medicare (HIB) card.		Medicare ID no.		Part A coverage start date	Part B coverage start date
Medicare Part D ID no.	Medicare Part D carrier				Part D effective date

Section 5: Family information — Please list yourself and all eligible family members to be enrolled. Attach additional sheets, if necessary.

To select a PCP and/or PCD, visit our website at empireblue.com/find-doctor. If your Empire benefit plan requires you to pick a PCP and/or PCD and you do not select one, we will assign one to you. You will be able to change to another PCP and/or PCD by contacting us.

Applicant					
Primary care physician (PCP) last name		PCP first name			PCP no.
Current patient of PCP? ☐ Yes ☐ No					
Primary care dentist (PCD) last name		PCD first name			PCD no.
Current patient of PCD? ☐ Yes ☐ No					
☐ Spouse ☐ Domestic partner					
Last name		First name		M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different			
PCP last name		PCP first name			PCP no.
Current patient of PCP? ☐ Yes ☐ No					
PCD last name		PCD first name			PCD no.
Current patient of PCD? ☐ Yes ☐ No					
Email address (requested for ages 18 and over): ______					
Please provide a copy of the Medicare (HIB) card.		Medicare ID no.		Part A coverage start date	Part B coverage start date
Medicare Part D ID no.	Medicare Part D carrier				Part D effective date

1 Empire is required by the Internal Revenue Service to collect this information.
2 Email address is required for the applicant.
3 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
4 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 5: Family information — Continued.

Dependent 1

Last name		First name		M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different			
PCP last name		PCP first name			PCP no.
Current patient of PCP? ☐ Yes ☐ No					
PCD last name		PCD first name			PCD no.
Current patient of PCD? ☐ Yes ☐ No					
Email address (requested for ages 18 and over):					
Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child ☐ Other If other, what relationship?					
Please provide a copy of the Medicare (HIB) card.		Medicare ID no.	Part A coverage start date		Part B coverage start date
Medicare Part D ID no.	Medicare Part D carrier				Part D effective date

Dependent 2

Last name		First name		M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different			
PCP last name		PCP first name			PCP no.
Current patient of PCP? ☐ Yes ☐ No					
PCD last name		PCD first name			PCD no.
Current patient of PCD? ☐ Yes ☐ No					
Email address (requested for ages 18 and over):					
Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child ☐ Other If other, what relationship?					
Please provide a copy of the Medicare (HIB) card.		Medicare ID no.	Part A coverage start date		Part B coverage start date
Medicare Part D ID no.	Medicare Part D carrier				Part D effective date

1 Empire is required by the Internal Revenue Service to collect this information.
2 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
3 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 5: Family information — Continued.

Dependent 3

Last name		First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different		
PCP last name		PCP first name		PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): ______

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? ______

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date
Medicare Part D ID no.	Medicare Part D carrier		Part D effective date

Dependent 4

Last name		First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different		
PCP last name		PCP first name		PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): ______

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? ______

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date
Medicare Part D ID no.	Medicare Part D carrier		Part D effective date

1 Empire is required by the Internal Revenue Service to collect this information.
2 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
3 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 6: Other medical coverage information — This section must be completed.

The questions in this section are for informational purposes only. The answers provided will have no bearing on eligibility.

Is anyone applying for coverage covered by other health coverage? ☐ Yes ☐ No **If yes, please complete the following:**

Name(s) of person(s) (first, M.I. last)	Insurance company name	Coverage dates	Provided by employer?	Employment status	Contract type
Self	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
☐ Spouse ☐ Domestic Partner	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 1	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 2	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 3	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)

Prior and other dental coverage information

Has any person applying for coverage had prior or other dental insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): ____________________

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: ____________________

Carrier name: ____________________ Carrier phone no.: ____________________ Member ID: ____________________

Date coverage began: ______ Date ended: ______ (MMDDYY)

Included orthodontia? ☐ Yes ☐ No

Section 7: Electronic Notice — This section is optional.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Empire has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Empire and/or Anthem Life to do either.

Applicant signature	Date (MMDDYY)
X	

Section 8: Terms, Conditions and Authorizations

Please read this section and the Insurance Fraud Statement below carefully before signing the application.

I am electing coverage as an employee, or former employee, retiree, current or former dependent of an active employee, or retiree, and am eligible for group coverage under the terms and conditions of the group's contract(s). I make this election on behalf of all eligible dependents and myself. I understand that I am under a continuing obligation to notify the group of a change in my, or my dependent's, status; such change may result in a change of insurance status with Empire or Anthem Life & Disability Insurance Company (Anthem Life) and that failure to make such notification may result in cancellation of the coverage by either carrier, subject to the incontestability clause of the contract.

I understand that if I become Medicare eligible while I am covered under the medical contract, any benefits I am entitled to under that contract will be reduced by the amounts paid by Medicare for those services, whether or not I apply for or submit a claim to Medicare.

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, including any health or other insurance company affiliated with Anthem Life, or employer having information available as to claims, diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Anthem Life, its affiliates, and any administrators, reinsurers, agents, providing services on behalf of Anthem Life, and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, and HIV/AIDS information, but excluding psychotherapy notes, and excluding substance use disorder records) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem Life representatives to evaluate and adjudicate my current application for life or disability coverage or any claims under such coverage, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem Life solely to assist with the evaluation and adjudication of my current life or disability application or claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards to any re-disclosed protected health information as applicable. I understand that Anthem Life may collect information about me, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws; any disclosure to third parties will be made in accordance with state and federal law. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.

This authorization, for purposes of processing this application form, is valid from the date signed for a period of 24 months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for a disability insurance benefit and for the duration of the claim if the claim is not for a disability insurance benefit. A photocopy and/or electronic copy is as valid as the original. The applicant or the applicant's authorized representative is entitled to receive a copy of this authorization.

If I select a coverage, or a combination of coverages, not available to me and/or a class for which I am not eligible, the insurers shall notify the employer of such differences, and seek the enrollees written consent to issue the different coverage.

I understand that Anthem Life reserves the right to accept or decline this application and that no right whatsoever is created by this application.

All statements and answers in this notice of election are true. Any material misrepresentation may result in Empire's or Anthem Life's cancellation of coverage which may result in an otherwise valid claim to be denied. The material misrepresentation must also be intentional in order to void the insurance contract or defeat recovery.

I certify each Social Security number submitted is correct.

Insurance Fraud Statement (does not apply to Life Insurance): Any person who knowingly and with intent to defraud an 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 material fact there to, 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 or each such violation.

Applicant signature	Print name	Date (MMDDYY)
X		

Important Accident Insurance eligibility information:

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:

This is ACCIDENT insurance only. This is a supplement to health insurance and is NOT a substitute for major medical or other comprehensive health insurance coverage. This policy only pays benefits related to a covered accident. IMPORTANT NOTICE — THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Important Specified Disease Insurance eligibility information:

The following notice(s) apply to all Specified Disease and Voluntary Specified Disease coverage presented on this form:

SPECIFIED DISEASE insurance is a supplement to health insurance and is NOT a substitute for major medical coverage. This is not a qualifying health coverage ("minimum essential coverage") that satisfies the health coverage requirement of the affordable care act. If you don't have minimum essential coverage, you may owe an additional payment with your taxes.

Important Hospital Indemnity Insurance eligibility information:

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

This is HOSPITAL INDEMNITY insurance only. This is a supplement to health insurance and is NOT a substitute for major medical or other comprehensive health insurance coverage. It pays a fixed dollar amount for covered benefits without regard to the health care provider's actual charges. The benefit payments are not intended to cover the cost of your medical care. These benefits are paid in addition to any other health insurance coverage you may have.

Section 9: Employer information — This section must be filled in by your group benefits administrator.

Group name			Group no.	Group sub no.
Street address		City	State	ZIP code
Employee no.	Payroll/Department location			Applicant's full-time employment start date
Authorized Group Benefits Administrator signature X	Print name			Date (MMDDYY)

Empire BlueCross BlueShield ● P.O. Box 1407, Church Street Station ● New York, NY 10008-1407 ● empireblue.com

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ivੱਚ ਮੁਫ਼ਤ ivੱਚ ਮਦਦ ਹਾisਲ ਕਰਨ ਦਾ iਅਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ iਦੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Protecting your privacy

How we keep your information safe and secure

As a member, you have the right to expect us to protect your personal health information. We take this responsibility very seriously, following all state and federal laws, as well as our own policies.

You also have certain rights and responsibilities when receiving your health care. To understand howwe protect your privacy, your rights and responsibilities when receiving health care, and your rights under the Women's Health and Cancer Rights Act, go to **empireblue.com/privacy**. For a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To see if your health benefits will cover a treatment, procedure, hospital stay, or medicine, we use a process called utilization management (UM). Our UM team is made up of doctors and pharmacists who want to be sure you receive the best treatments for certain health conditions. They review the information your doctor sends us before, during, or after your treatment. We also use case managers. They're licensed health care professionals who work with you and your doctor to help you manage your health conditions. They also help you better understand your health benefits.

For additional information about how we help manage your care, go to **empireblue.com/memberrights**. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

Special enrollment rights

Open enrollment usually happens once a year. That's the time you can choose a plan, enroll in it, or make changes to it. If you choose not to enroll, there are special cases when you're allowed to enroll during other times of the year.

- **If you had another health plan that was canceled**. If you, your dependents, or your spouse are no longer eligible for benefits with another health plan (or if the employer stops contributing to that health plan), you may be able to enroll with us. You must enroll within 31 days after the other health plan ends (or after the employer stops paying for the plan). For example: You and your family are enrolled through your spouse's health plan at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in one of our plans.
- **If you have a new dependent.** You gain new dependents from a life event, such as marriage, birth, adoption, or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you marry, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes**. You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or the State Children's Health Insurance Program (SCHIP) benefits because you're no longer eligible..
  - You (or eligible dependents) become eligible to receive help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

For full details, read your plan documents, which contain everything you need to know about your plan. You can find them on **empireblue.com**.

Notes

Have any questions about your plan?

Your benefits administrator or human resources representative will contact you soon with specific enrollment instructions for your organization.

If you have questions, please contact:

Please call us at 800-662-5193,

Monday to Friday, 8:30 a.m. to 5 p.m., Eastern time.

Your plan is here for you to use

If you would like extra help

Empire Health Guides are here to help you make the most out of your medical plan. These highly trained Empire associates will help you with all your health care needs.

Reach a health guide by calling the number on your member ID card. You also can go to **empireblue.com** to send a secure email or chat with them online.

An Anthem Company

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Google Play and the Google Play logo are trademarks of Google LLC.

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