Empire BlueCross

Benefits You Can Count On

Janitronics
Prism EPO / Total Blue EPO with HSA / Dental prime /
Blue View Vision

Choosing the right plan is a very personal thing.

Use this book to find one that's

- Right for your lifestyle
- Right for your needs
- Right for your peace of mind

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Your guide to Empire

Welcome! We're so glad you're taking time to check out all that Empire has to offer you. Choosing your health care plan (and the benefits that go with it) is an important decision and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with our health plan(s). It shows what's available to you, what you get with each benefit and how the plan(s) work.

Explore the advantages of being an Empire member.

This booklet goes into all the advantages. But here are the top four:

1. **Our plans can help you stay healthy.** Health plans aren't just something you need when you're sick. We offer easy-to-use plans that are specially designed for people who already have healthy lifestyles.
2. **You get more than just basic coverage.** You get access to tools, resources and guidance that are customized just for you. Plus we offer online programs to help you get and stay healthy. They'll help you reach your personal goals to be as healthy as possible.
3. **There's so much you can do on our website – after all, it was created just for you.** If you have questions, you'll find the answers you're looking for. Here are some things you can do:
   - Check the status of a claim
   - Search for a doctor, specialist or hospital
   - Learn about hundreds of health and wellness topics
4. **Finding an in-network doctor, specialist or hospital is a snap.** It's quick and easy to search online. You can make your search specific by choosing a specialty or entering a doctor's name. And if you're away from home, try searching our National Directory.

Once you get your member ID card, all it takes is three simple steps to discover the world of empireblue.com.

- Go to empireblue.com
- Click on Register
- Create your username and password.

Then you're ready to go!

For any assistance, please call us at 800-662-5193, Monday to Friday, 8:30 a.m. to 5 p.m., Eastern time.

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Your guide to Empire (continued)

Join our health conversation.

We've brought together a community of health enthusiasts who share information, tips and inspiration on Facebook, Twitter and YouTube. Follow our pages to get exercise tips from people like you. Get advice on reaching your health and wellness goals. And find things like healthy recipes and exercise how-to videos from our health coaches and trainers.

Connect with us today!

- Facebook.com/HealthJoinIn
- Twitter.com/HealthJoinIn
- YouTube.com/HealthJoinIn

We're teaming up with IBM Watson to help you get the best care.

At times, getting a diagnosis for a complex or rare health issue can be a long, tough process. It's been found that 15-20% of medical errors are caused by a delayed diagnosis.* To help with this issue, we are teaming up with IBM to pioneer a tool using their IBM Watson technology. This tool will help doctors use more complete information about a patient to make a diagnosis. And it will assist them in recommending treatments.

IBM Watson is being developed to access and analyze vast libraries of medical information and millions of health data records. With IBM Watson at their fingertips, we expect that our in-network doctors will be able to make more informed decisions about your health care. And that gets you on the road to your best health quicker.

Visit our website to easily find a doctor or facility.

Scan the code with your mobile capable device for a direct link to empireblue.com. Don't have a QR code reader? Download the free ScanLife app to your mobile device or visit scanlife.com.

* Dr. Herb Chase, Columbia University School of Medicine, IBM IBV report, The Future of Connected Healthcare Devices, March 2011.

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Helpful links

empireblue.com

Facebook.com/HealthJoinIn

While you're there check out the Health Personality Quiz

Twitter.com/HealthJoinIn

YouTube.com/HealthJoinIn

Healthy Footprint

Member Online Tools

Your Health Benefits

Empire Prism℠ EPO

The big buzz these days is that you can take charge of your health care. That's why we build our health plans to provide options, resources and overall support to help you make decisions. But we also believe in hassle-free health care coverage and have built our plans with that in mind.

One, you have flexibility. We offer an extensive network of physicians and hospitals so that you can choose the right doctor or hospital for you.

Two, as an Empire member, you have access to many online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions — for you, your health and your budget.

How to find a network provider

1. Go to empireblue.com
2. Select "Find a Doctor"
3. Follow the prompts

Other ways you can take charge with Empire Prism EPO:

- *You pay nothing for in-network covered preventive care.* Staying healthy is one of the best ways to save money. Use a network provider and Empire Prism EPO plan covers your routine physicals, certain immunizations and certain well-care 100 percent.
- *You don't need a referral.* As long as you see an in-network doctor or specialist for medically necessary covered services, you pick who you want to see. You don't need your doctor or our approval.
- *You're covered in many places away from home.* Access physicians and hospitals, participating through the BlueCard® PPO program, across the country. And with BlueCard® Worldwide, if you're traveling and need care, you have access to covered health care services in locations in Europe, the Caribbean, Latin America, Asia, the South Pacific, Africa and the Middle East.
- *You get more than just a health plan.* You get programs to actually help you manage your health. MyHealth, 24/7 Nurseline and SpecialOffers are all available through 360° Health® at empireblue.com. Plus you have 24/7 access to your plan information so you get the help you need when you need it.

Your Summary of Benefits

Prism EPO

Janitronics - Prism EPO

Benefit	In-Network[2]
Deductible	$1,000/$2,500
Coinsurance	20%
Total Out-of-Pocket Maximum (Includes deductible, coinsurance and medical copayments)	$3,000/$7,500
Lifetime Maximum	Unlimited
Dependent Children (covered to the end of the month of the dependent's birthday)	Dependents to Age 26
Covered Preventive Care[7]	**Member Pays In-Network**
Covered Adult Preventive Care	$0 copayment
Annual Physical Exam	$0 copayment
Well-Child Care (to age 19; including necessary covered immunizations)	$0 copayment
Preventive Well-Woman Care	$0 copayment
Home/Office/Outpatient Care[1]	**Member Pays In-Network**
Home/Office Visits	$25/$40 copayment
Urgent Care Center	$40 copayment
Online Visits	$25 copayment
Emergency Room/Facility (initial visit per occurrence)	$150 copayment (waived if admitted within 24 hours)
Ambulatory Surgery[4]/Outpatient Surgery Presurgical Testing, Anesthesia Chemotherapy, Radiation Therapy Chiropractic Care[6] MRI[3], MRA[3], CAT Scan[3], PET[3] & Nuclear Cardiology[3] Laboratory Tests, X-rays[7]	$25/$40 copayment will apply to visit services (examinations and evaluations); Other services performed will be subject to in-network Deductible and Coinsurance
Routine Maternity Care	Deductible and Coinsurance
Allergy Care - Office Visit - Routine Testing - Allergy Injections/Immunotherapy	 $25/$40 copayment Deductible and Coinsurance $0
Home Healthcare (Up to 100 visits per plan year)	Coinsurance (no deductible)
Home Infusion Therapy	Deductible and Coinsurance
Hospice Care (Unlimited days combined IP & OP per lifetime)	Deductible and Coinsurance
Physical Therapy[4] (Up to 60 visits per plan year combined in home, office or outpatient facility)	
Other Short-Term Rehabilitative Therapies – Speech/Language[4], Occupational[4], Vision (Up to 30 visits per plan year combined in home, office or outpatient facility)	$25/$40 copayment for visit services; Other services performed subject to in-network Deductible and Coinsurance

Your Summary of Benefits

Prism EPO

Benefit	In-Network[2]
Cardiac Rehabilitation Second Surgical Opinion Kidney Dialysis	$25/$40 copayment for visit services; Other services performed subject to in-network Deductible and Coinsurance
Inpatient Care[4]	**Member Pays In-Network**
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	Deductible and Coinsurance
Surgery, Covered Surgical Assistant, Anesthesia	Deductible and Coinsurance
Physical Therapy, Physical Medicine or Rehabilitation (Up to 60 inpatient days per plan year)	Deductible and Coinsurance
Skilled Nursing Facility (Up to 60 inpatient days per plan year)	Deductible and Coinsurance
Mental Health	**Member Pays In-Network**
Outpatient Visits in Office	$25 copayment
Outpatient Visits in a Facility	Coinsurance (no deductible)
Inpatient Care[5] (As many days as is medically necessary; semiprivate room and board)	Deductible and Coinsurance
Alcohol/Substance Abuse	**Member Pays In-Network**
Outpatient Visits in Office	$25 copayment
Outpatient Visits in Facility	Coinsurance (no deductible)
Inpatient Detoxification[5] (As many days as is medically necessary; semiprivate room and board)	Deductible and Coinsurance
Inpatient Rehabilitation [5]	Deductible and Coinsurance
Other	**Member Pays In-Network**
Medical Supplies	Deductible and Coinsurance
Durable Medical Equipment[3]	Deductible and Coinsurance
Prosthetics & Orthotics[3]	Deductible and Coinsurance
Ambulance (air ambulance)	Deductible and Coinsurance
Prescription Drugs[8] Retail Program – One copayment required for up to a 30-day supply	$0 Deductible per person per plan year Deductible does not apply to Tier 1 Generic drugs Tier 1/Tier 2/Tier 3 $10/$35/$70 copayment Includes Contraceptives (Retail & Mail-Order)
Mail-Order Program[9] – Only two copayments required for a 90-day supply	$0 Deductible The Mail-Order Program has the same copayments as the Retail Program listed above.

Prism EPO

(1) The following practitioners receive the lower (primary) copayment for services provided in an office: Patient's PCP, obstetrics, gynecologists, certified nurse midwives, chiropractors, and physical, occupational, speech and vision therapists. The higher (specialist) copayment will apply for all other specialists when a Copayment is required, and for services received in an outpatient facility for physical and other speech, language, occupational, vision and radiation therapy.

(2) A network provider must deliver all care, except in emergencies. The in-network office co-payment applies to examinations and evaluations only. Other services performed during office visits are subject to in-network deductible and coinsurance (unless otherwise indicated). There is no out-of-network option for this product.

(3) For services received from an Empire network provider, the provider must precertify services or services may be denied. Empire's network providers cannot bill member except for co-payments for office visit examinations and evaluations services and the in-network deductible and coinsurance for other covered services (for services subject to cost share). Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for non-emergency services from in-network BlueCard® PPO providers (with the exception of MRI, MRA, PET, CAT and Nuclear Cardiology services, which do not require precertification for services rendered from in-network BlueCard® PPO providers outside of Empire's network area).

(4) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, *please call the toll-free number on your member ID card to determine exactly what outpatient services require precertification.*

(5) You are responsible for obtaining precertification from Empire's Behavioral Healthcare Management Program. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.

(6) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services, or services may be denied: Empire network providers cannot bill members except for co-payments for office visit examinations and evaluations and the in-network deductible and coinsurance for other covered services (for services subject to cost share). Authorization is not required for services received from in-network BlueCard® PPO providers outside of Empire's network area.

(7) Preventive Care benefits not subject to copayment, deductible and coinsurance; when provided In-Network include; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.

(8) The prescription drug plan listed on this Benefits Summary, except Option 4, meets the CMS standard for Creditable Coverage under the Medicare Modernization Act of 2003.

(9) To receive a 90-day supply of prescription drugs through Empire's Mail-Order Program, the prescription must be written specifically for a 90-day supply.

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in your Certificate of Coverage, Schedule of Benefits, and any additional Riders or Contracts your group has purchased. Be sure to consult your benefit Contract or Certificate for full details about your coverage. To the extent that there is a conflict between this Summary and your benefit Contract or Certificate, the terms of the Contract or Certificate will control. Failure to comply with Empire's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Empire Total Blue℠ EPO with HSA

The fact is, good health not only feels better, it typically costs less, too. Doing what's best for your health is not a short-term fix; it's a long-term solution. And over the long term, living a healthier life can help you save money. Empire Total Blue EPO with HSA (Health Savings Account) is designed to help you do both.

Health care dollars to spend your way – and save for the future

One of the most unique aspects of Empire Total Blue is you'll have an account set up — like a bank account — for your health care dollars. The account is available to help offset the costs you'll pay for services and prescriptions. But you decide. You can use your HSA to pay for these expenses or you may pay from your own personal funds to save HSA dollars. You're in control.

As you pay for covered services and prescriptions, you're paying down the plan's deductible. If you use all your HSA funds before the deductible is met, you're responsible for the difference. After that the traditional plan coverage kicks in, helping you pay for any additional expenses.

If you have a healthy year with little expenses, and have funds left over in your HSA, it will roll over to the next year and earn tax-free interest. You may also choose to invest your funds if the account reaches a certain dollar amount.

Taking care of your health today may help you save for your future health care needs. But don't think you're alone! Empire has many health and financial tools to help you make the right decisions for you, your health and your budget.

Other ways you're in control with Empire Total Blue:

- *You pay nothing for in-network covered preventive care.* Use a network provider and Empire Total Blue covers your routine physicals, certain immunizations and certain well-care 100 percent.
- *You don't need a referral.* You pick who you want to see. You don't need your doctor or our approval.
- *You can see what a service costs before your appointment.* Through empireblue.com and our Treatment Cost Advisor™, you can estimate the costs for certain hospital services and doctor visits. What better way to help you determine what to do?
- *You're covered no matter where you go.* Access physicians and hospitals, participating through the BlueCard® PPO program, across the country. And with BlueCard® Worldwide, if you're traveling and need urgent care, you have access to covered health care services in Europe, the Caribbean, Latin America, Asia, the South Pacific, Africa and the Middle East.
- *You get more than just a health plan.* You get the tools to help you manage your health. MyHealth, 24/7 Nurseline and SpecialOffers are all available at empireblue.com. Plus you have day or night access to your plan information so you get the help you need when you need it.

Empire Total Blue℠ EPO with HSA (continued)

How Empire Total Blue with HSA works

1. First, use the funds available in your health account (HSA), if you choose, to pay for covered medical care and prescriptions.
2. Then, if you spend all of your HSA funds, you'll pay a limited amount — the annual deductible.
3. Once the deductible is met, the traditional health coverage begins, which helps protect you from further health care expenses.
4. If you do not spend all of your HSA dollars, and you have money remaining in your account at the end of a plan year, it rolls over to the following year and earns interest.
5. Also, you own the HSA; if you retire or leave your employer, the money is yours to keep.

A few weeks after enrolling in your plan, you'll receive an HSA Welcome Kit from your HSA financial institution. The kit will contain all the necessary information you'll need to activate your HSA and access your account.

Other things to know about the health savings account

What you may contribute to the HSA

According to the IRS, you are eligible to contribute to an HSA if you are covered by an HSA-compatible health plan, such as Empire's HSA plan, not enrolled in Medicare, and not claimed as a dependent on someone else's tax return.

All combined contributions to your account (meaning yours and your employer's, if applicable) cannot exceed $3,300 for individual coverage and $6,550 for family coverage. If you will be age 55 or older, and you are not enrolled in Medicare, you are eligible to contribute an additional amount (referred to as a catch-up contribution) of $1,000. These amounts may increase for inflation annually. Check the Empire online health site for the most current maximums.

Your HSA generates tax savings, too

Not only can you build up funds in your HSA to pay for future health care expenses, but you save money on taxes each year. Here's how your HSA can generate tax savings for you:

- Contributions you may make through paycheck deductions (if available through your employer) are made with pretax dollars, meaning they are not subject to federal taxes.
- Contributions made with after tax dollars (meaning you send a check to the HSA financial institution) can be deducted from your gross income at the end of the year.
- The interest you earn on your HSA funds is not taxed.
- Withdrawals from your HSA for qualified medical expenses are not subject to federal income tax.

Empire Total Blue℠ EPO with HSA (continued)

Things to consider when it comes time for tax planning:

- If you are an active employee and your employer contributes to your HSA, it will be reported on your W-2 form.
- You will receive a 1099 form and a 5498 form in the mail near tax time so you can file your taxes. You will have to complete an 8889 form when you file your taxes.
- In addition, you need to keep track of your receipts for anything you pay for from your account in the event you need to provide documentation to the IRS to show you used any HSA funds on qualified medical expenses.

Please consult a tax advisor to ensure you file your taxes correctly.

Your HSA can pay for expenses covered by the plan, and then some

The IRS allows you to use your HSA funds to pay for "qualified medical expenses" that may not be covered by your health plan. Examples of these are braces, dental care, hearing aids, LASIK surgery and contact lenses. For a complete listing of what is allowed, go to the IRS website at irs.gov.

Here's what happens when you seek care

For illustrative purposes, here is an example of what will happen when you visit an in-network doctor.

1. You seek care from your doctor and pay nothing at the office.
2. Your doctor submits the office visit claim for $100 (example cost).
3. Empire processes the claim at a discounted rate = $60 (example discount).
4. Empire applies the $60 toward your in-network deductible.
5. Empire sends an explanation of benefits (EOB) to your doctor.
6. Empire sends an EOB to you showing your responsibility.
7. Doctor bills you for $60.
8. You choose to pay $60 from your HSA by check or debit card, or from other personal funds to save HSA dollars.

A similar situation occurs when you fill a prescription at a retail, in-network pharmacy. The only difference is you'll pay for the prescription at point of purchase, either from your HSA by check or debit card or from your personal funds.

This is a brief overview of your plan's features. Your evidence of coverage or medical policy contains the details. Or, call us with any questions: 800-662-5193, Monday to Friday, 8:30 a.m. to 5 p.m., Eastern time.

HSA

Janitronics
Total Blue EPO w H.S.A.

Benefit	In-Network[1]
In-Network Deductible (Individual / Family) *Family Deductible is 2x the individual deductible*	$2,000/$4,000
In-Network Coinsurance (member responsibility)	0%
In-Network Coinsurance Out-of-Pocket Max	$0
In-Network Annual Total OOP Max (includes Rx Copayments) *Any one individual or multiple individuals can satisfy the family OOP maximum*	$2,000/$4,000
Lifetime Maximum	Unlimited
Dependent Children (covered to the end of the month of the dependent's birthday)	Dependents to Age 26
Covered Preventive Care[2]	**Member Pays**
Covered Adult Preventive Care	$0 (covered 100%)
Physical Exam (One per plan year)	$0
Well-Child Care (Up to age 19; including necessary covered immunizations)	$0
Preventive Well-Woman Care	$0
Home/Office/Outpatient Care	
Home/Office Visits/Outpatient	Deductible
Online Visits	Deductible
Emergency Room/Facility	Deductible
Urgent Care Center	Deductible
Surgery[3], Presurgical Testing, Anesthesia	Deductible
Chemotherapy, Radiation Therapy	Deductible
Routine Maternity Care	Deductible
Laboratory Tests[2], X-rays[2]	Deductible
Cardiac Rehabilitation	Deductible
Second Surgical Opinion	Deductible
Kidney Dialysis	Deductible
MRI[5]/MRA[5], CAT[5], PET[5] and Nuclear Cardiology[5]	Deductible
Allergy Care: Routine Testing & Treatment (Allergy Injections/Immunotherapy)	Deductible
Chiropractic Care[6]	Deductible
Home Healthcare (Up to 100 visits per plan year)	Deductible
Home Infusion Therapy	Deductible
Hospice Care (Unlimited days per lifetime)	Deductible
Physical Therapy[3] (Up to 60 visits per plan year combined in home, office or outpatient facility)	Deductible
Other Short-Term Rehabilitative Therapies – Speech/Language[3], Occupational[3], Vision (Up to 30 visits per plan year combined in home, office or outpatient facility)	Deductible

Your Summary of Benefits

HSA

Benefit	In-Network[1]
Inpatient Care[3]	**Member Pays**
Inpatient Hospital (As many days as are medically necessary; semiprivate room and board)	Deductible
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 60 inpatient days per plan year)	Deductible
Surgery, Surgical Assistant, Anesthesia	Deductible
Skilled Nursing Facility (Up to 60 days per plan year)	Deductible
Birthing Centers	Deductible
Mental Health	
Outpatient Visits in Office or Facility	Deductible
Inpatient Care[4] (As many days as are medically necessary; semiprivate room and board)	Deductible
Alcohol/Substance Abuse	
Outpatient Visits	Deductible
Inpatient Detoxification[4] (As many days as are medically necessary; semiprivate room and board)	Deductible
Inpatient Rehabilitation	Deductible
Other	
Medical Supplies	Deductible
Durable Medical Equipment[5]	Deductible and 50% Coinsurance (Diabetic diagnosis applies Deductible and 100% Coinsurance) – Applies to OOP max
Prosthetics & Orthotics[5]	Deductible and 50% Coinsurance (includes diabetic diagnosis) – Applies to OOP max
Ambulance (Land/Air ambulance)	Deductible
Prescription Drugs	Once the integrated deductible is met, prescription drugs are covered at 100% for both Retail and Mail Order Pharmacy. Creditable Cvg

(1) Network provider delivers care. There is no out-of-network option for this product, except for emergency care.
(2) Preventive Care benefits not subject to copayment, deductible and coinsurance; when provided In-Network include; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
(3) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, please call the toll-free number on your member ID card to determine exactly what outpatient services require pre-certification.
(4) Precertification is required by Empire's Behavioral Healthcare Management Program.
(5) For services received from an Empire network provider, the provider must precertify in-network services; Empire network providers cannot bill members for covered services. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers (with the exception of MRI, MRA, PET, CAT and Nuclear Cardiology services, which do not require precertification for services rendered from in-network BlueCard PPO providers outside of Empire's network area.) The BlueCard PPO provider may call for you for services that do require precertification, but you will be responsible for penalties applied if precertification is not obtained.
(6) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services; Empire network providers cannot bill members beyond the in-network copayment for covered services. Authorization is not required for services rendered from in-network BlueCard PPO providers outside of Empire's network area.You are responsible for obtaining precertification for services received from an out-of-area BlueCard PPO provider. The provider may call for you, but you will be responsible for penalties if precertification is not obtained.

Your Summary of Benefits

HSA

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in your Certificate of Coverage, Schedule of Benefits, and any additional Riders or Contracts your group has purchased. Be sure to consult your benefit Contract or Certificate for full details about your coverage. To the extent that there is a conflict between this Summary and your benefit Contract or Certificate, the terms of the Contract or Certificate will control. Failure to comply with Empire's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions.

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Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Take care of yourself

Remember to get preventive care

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans cover 100% of the services listed in this preventive care flier.[1] When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses.

For example, say your doctor suggests you have a colonoscopy because of your age. That's preventive care. On the other hand, say your doctor suggests a colonoscopy to see what's causing your symptoms. That's diagnostic care and you may need to pay part of the cost.

Here's a listing of the types of preventive services we cover. See your benefit plan to learn more.

Child preventive care (birth through 18 years)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests (depending on your age) may include

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Fluoride supplements for childrenfrom birth through 6 years old6
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Iron supplements for children 0-12 months6
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Type 2 diabetes screening
- Vision screening[2] when done as part of a preventive care visit

Take care of yourself (continued)

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV) Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chicken pox)

Adult preventive care (19 years and older)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests and services (depending on your age) may include

- Aortic aneurysm screening (men who have smoked)
- Blood pressure
- Bone density test to screen for osteoporosis
- Breast cancer, including exam and mammogram
- Breastfeeding support, supplies and counseling (female)[3, 4]
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- Contraceptive (birth control) counseling and FDA-approved contraceptive medical services provided by a doctor, including sterilization (female), and FDA-approved prescribed or women's over-the-counter contraceptives[4, 5]
- Depression screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- HPV (female)[4]
- Intervention services (includes counseling and education):
  - Behavioral counseling to promote a healthy diet
  - Counseling related to aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79[6]
  - Counseling related to genetic testing for women with a family history of ovarian or breast cancer, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[7]
  - Counseling related to chemoprevention for women with a high risk of breast cancer

Take care of yourself (continued)

- Folic acid for women 55 years old or younger6
- Primary care intervention to promote breastfeeding[3,4]
- Screening and behavioral counseling related to alcohol misuse
- Screening and behavioral counseling related to tobacco use including tobacco cessation products[8]
- Screening and counseling for interpersonal and domestic violence
- Screening and counseling for obesity
- Vitamin D for women over 65

- Pelvic exam and Pap test, including screening for cervical cancer
- Prostate cancer, including digital rectal exam and PSA test
- Screenings during pregnancy (including, but not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)[4]
- Screening and counseling for sexually transmitted infections

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A
- Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- MMR
- Pneumococcal (pneumonia)
- Varicella (chicken pox)
- Zoster (shingles)

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions & Limitations.

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your certificate of coverage or call the Customer Care number on your ID card.

2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

3 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

4. This benefit also applies to those younger than 19.

5 To get 100% coverage for birth control, you must present a prescription at an in-network pharmacy for a generic drug, a brand-name drug that doesn't have a generic equivalent, or an OTC item like female condoms or spermicide. A cost share may apply for other prescription contraceptives, based on your drug benefits.

6. To get 100% coverage, you will need to present a prescription from a doctor or other health care provider at an in-network pharmacy.

7. Check your medical policy for details.

8. For those 18 years and older. 100% coverage of tobacco cessation products requires a prescription from a doctor that must be presented at an in-network pharmacy. Coverage is provided for select generic products, brand-name products with no generic alternatives, and FDA-approved over-the-counter products.

Your pharmacy benefits

We're glad you're part of our prescription drug plan. We think it's important for you to have access to a wide range of affordable medicines. And we work hard to provide you with the best service. If you have any questions about your plan, call us at the phone number on your member ID card.

Save money on your prescriptions

Here are some easy ways to get the most from your plan – and save on your medicine.

Choose the drugs you need from our drug list

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand-name and generic drugs. We research drugs and choose ones that are safe, work well and offer the best value. Sometimes we update the drug list when new drugs come to market, or if new research becomes available. If your plan uses a tiered drug list, view the drugs we cover at www.empireblue.com/national3tierebc.

You'll save money by taking medicines that are on the drug list. Drugs that aren't on the list may have a higher copay or may not be covered, depending on your plan.

Also, some drugs need our review and need to get an OK from us before the prescription is filled to make sure they're covered. This is called **prior authorization**. This review focuses mainly on drugs that may have:

- A risk of serious side effects or drug interactions
- High potential for incorrect use or abuse
- Better alternatives that may cost less
- Rules for use with very specific conditions

Your pharmacist will tell you if your drug needs prior authorization.

Try generic drugs

Generics drugs cost much less than most brand-name drugs. So ask your doctor if a there's a generic choice for your medicine – and if it might work for you. Generic drugs are approved by the Food and Drug Administration (FDA) and work as well as the brand-name choices.

Use over-the-counter (OTC) drugs when you can

You don't need a prescription for OTC drugs. They often have the same active ingredients as the prescription versions but usually cost a lot less. OTC allergy and heartburn medicines are good examples. Just ask your doctor if it's okay to swap your prescription drug for an OTC medicine.

Your pharmacy benefits (continued)

Visit in-network pharmacies

Our retail pharmacy network includes more than 64,000 pharmacies across the country, including major chains, grocery stores and independent pharmacies. That means you have easy access to your medicine wherever you are – at work, at home or even on vacation. Using pharmacies in the network will help save money. And when picking up your prescription at the pharmacy, don't forget to show your member ID card.

To make sure your pharmacy is in our network, visit **empireblue.com**. Log in and click on **Go to the Pharmacy**. Then click on **Access Your Pharmacy Benefits**. You will be sent to the Express Scripts website. Click on **Find a Pharmacy**.

Sign up for our convenient Home Delivery Pharmacy

Home delivery is a safe, easy way to get medicine you need on a regular basis. Prescriptions are sent to your home within two weeks from the time the pharmacy gets your order. Pharmacists can answer your drug questions by phone any time. Plus, you may be able to save money on your medicine.

Our Home Delivery Pharmacy is managed by Express Scripts. See the next page to learn how to get started.

Get support from our specialty pharmacy

Accredo, the Express Scripts specialty pharmacy, provides medicine and support and for people with complex and long-term conditions. Specialty drugs come in different forms like pills or liquids. And some need to be injected, infused or inhaled. These drugs often need special storage and handling and may be given to you by a doctor or nurse.

Accredo's programs help people with some complex conditions. These programs teach you about treatment for your condition and help you understand and cope with drug side effects.Nurses and pharmacists will even set up time with you to find out how you are doing.

Call 888-773-7376, Monday through Friday, 8 a.m. to 9 p.m., Eastern time, to learn how Accredo's condition support programs can help you better manage your health condition.

Information at your fingertips

Wherever you are, you can easily access your pharmacy information online.

Check out empireblue.com

Log in and click on **Go to the Pharmacy**. Then click on **Access Your Pharmacy Benefits**. You'll be sent to the Express Scripts website. There you'll have access to lots of tools and drug information, all in one spot. You can check order status, order refills, price a drug, renew a prescription and much more.

EXPRESS SCRIPTS®

HOME DELIVERY PHARMACY ORDER FORM

To MAIL your prescription:
1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:
   Express Scripts Home Delivery Service
   PO Box 66558
   St. Louis MO 63166-6558

To FAX your prescription:
1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-866-272-8856
   - **Class II prescriptions cannot be faxed.**
   - Faxes will only be accepted from a doctor's office.

PATIENT

Member ID: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

_____

E-mail: _____

Allergies: _____

_____

Health Conditions: _____

_____

_____

Over-the-Counter Medications: _____

_____

DOCTOR/PRESCRIBER

DEA: _____

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

PATIENT OPTIONS

☐ I want non-child resistant caps, when available.
☐ I want a copy of my bottle label in large print on a separate sheet of paper.
☐ Check here for rush delivery. Once your order is received and filled, it will be shipped overnight for $21.

If you want to make a payment or update your health conditions, please visit your health plan provider's website.

2161

Rx

_____ _____ **Date:** __ __ / __ __ / __ __

First Name **Last Name**

Drug Name/Form/Strength	Qty	Directions for Use	Refills

X _____ **X** _____

Doctor/Prescriber Signature – Substitution Permissible

Doctor/Prescriber Signature – Dispense as Written

Stamped signatures cannot be accepted.

Additional Benefits

Dental Prime

Everyone wants a nice smile. But did you know taking care of your teeth and seeing your dentist for regular checkups can actually help protect your overall health? More than 90% of all diseases that impact your body produce signs and symptoms in your mouth.[1] Dental Prime can help you keep your smile bright and healthy.

HOW TO FIND A DENTAL PROVIDER

1. **Go to empireblue.com.**
2. **Click on "Find a Doctor."**
3. **Click on "Select a dental provider near you,",then choose Dental Prime in the plan drop-down box.**
4. **Enter search choices and click on "View Results."**

Advantages of Dental Prime:

- **Your dentist is likely in the network.** In fact, you have access to more dentists and specialists than most other dental plans. To see if your dentist, orthodontist or periodontist is in the Dental Prime network, use the "Find a Doctor" tool on empireblue.com.
- **Dental Prime covers a variety of services.** Whether you need a regular cleaning or filling, Dental Prime offers coverage. For details of what the plan covers, see the summary of benefits or talk to your benefits manager.
- **You get more for the money.** SpecialOffers gives you discounts on wellness products and services, like fitness club memberships and LASIK eye surgery.[2]
- **You have access to worldwide dental emergency care.** Members traveling outside the U.S. are covered for emergency dental services through a worldwide network of English-speaking dentists.[3]
- **The support you need.**
  - Visit empireblue.com for online services, forms, dental health tips and more.
  - Call our dedicated dental customer service line at the number on the back of your ID card.

1 Academy of General Dentistry website: Importance of Oral Health to Overall Health (October 2008): http://www.knowyourteeth.com/infobites/abc/article/?abc=0&iid=320&aid=1289.
2 Vendors and offers are subject to change without prior notice. Empire does not endorse and is not responsible for products, services, or information provided by these vendors. Arrangements and discounts were negotiated between each vendor and Empire for the benefit of our members.
3 The International Emergency Dental Program is managed by DeCare Dental. DeCare Dental is an independent company offering dental management services to Empire.

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WELCOME TO YOUR DENTAL PLAN!

This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your employee benefits booklet.

Dental coverage you can count on

Your Empire dental plan lets you visit any licensed dentist or specialist you want - with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits - you get more for your money.

You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE	In-Network	Out-of-Network
Annual Benefit Maximum Calendar Year		
▪ Per insured person	**$750**	**$750**
Annual Maximum Carryover	**No**	**No**
Orthodontic Lifetime Benefit Maximum		
▪ Per eligible insured person	**N/A**	**N/A**
Annual Deductible		
▪ Per insured person	**$0**	**$0**
▪ Family maximum	**3X Individual**	**3X Individual**
Deductible Waived for Diagnostic/Preventive Services	**Yes**	**Yes**
Out-of-Network Reimbursement Options:	**Prime (MAC)**	
Dental Services	In-Network Empire Pays:	Out-of-Network Empire Pays:
Diagnostic and Preventive Services, for example:	100% Coinsurance	100% Coinsurance
▪ Periodic oral exam		
▪ Teeth cleaning (prophylaxis)		
▪ Bitewing X-rays: 2X per 12 months		
▪ Intraoral X-rays		
Basic Services	80% Coinsurance	80% Coinsurance
Fillings, for example:		
▪ Amalgam (silver-colored)		
▪ Front composite (tooth-colored)		
▪ Back composite, Covered as Composites		
Basic or Major Services		
Crowns	50% Coinsurance	50% Coinsurance
Prosthodontics, for example:	50% Coinsurance	50% Coinsurance
▪ Dentures		
▪ Bridges		
▪ Dental implants Not Covered		
Prosthetic Repairs/Adjustments	80% Coinsurance	80% Coinsurance
Endodontics, for example:	80% Coinsurance	80% Coinsurance
▪ Root Canal		
Periodontics, for example:	80% Coinsurance	80% Coinsurance
▪ Scaling and root planing		
Oral Surgery	80% Coinsurance	80% Coinsurance
Waiting Period for Basic Services*: No Waiting Periods		
Waiting Period for Major Services*: No Waiting Periods		
Orthodontic Services		
·None	Not Covered	Not Covered
Waiting Period*: N/A		

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your employee benefits booklet. In the event of a discrepancy between the information in this summary and the employee booklet, the employee booklet will prevail.

*Waiting periods will be waived for initial enrollees if replacing 12 months prior credible dental coverage.

EBC_PCLG_ASO-Custom

Emergency dental treatment for the international traveler

As an Empire dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.** With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Empire Blue Cross Insurance Company.

Promoting healthy mouths for members who are pregnant or living with diabetes

If you are pregnant or living with diabetes, you can sign up to receive one additional dental cleaning or periodontal maintenance procedure per year.

Finding a dentist is easy.

To select a dentist by name or location, do one of the following:

- Go to empireblue.com
- Call Customer Service at the toll-free number listed on the back of your ID card.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Calendar Year

Teeth cleaning (prophylaxis) Limited to two per Calendar Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Coverage Every 3 Years

Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services. Please see your dental proposal page to determine your coverage.

Basic and/or Major Services***

Fillings Limited to once per surface per tooth in any 24 months

Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; Space Maintainers may be covered under Diagnostic and Preventive or Basic Services.

Crowns Limited to once per tooth in a seven-year period

Fixed or removable prosthodontics – dentures, partials, bridges

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 36 months when the tooth pocket has a depth of four millimeters or greater

Brushed Biopsy Standard - Covered

***Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.

There is a 12-month waiting period for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage for a full list.

Services provided before or after the term of this coverage

Services received before your effective date or after your coverage ends, unless otherwise specified in the employee benefits booklet

Orthodontics (unless included as part of your dental plan benefits) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Extractions Surgical removal of asymptomatic, nonpathologic third molars

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Empire Blue Cross Blue Shield Insurance Company.

Choice of dentists
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why:

In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed amount" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

How Empire dental decides on maximum allowed amounts
For services from an out-of-network dentist, the maximum allowed amount is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

Here's an example of higher costs for out-of-network dental services
This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Ted gets a crown from an out-of-network dentist, who charges $1,200 for the service and bills Empire for that amount.
Empire's maximum allowed amount for this dental service is $800. That means there will be a $400 difference, which the dentist can "balance bill" Ted.

Since Ted will also need to pay $400 coinsurance, the total he'll pay the out-of-network dentist is $800.
Here's the math:

- Dentist's charge: $1,200
- Empire's maximum allowed amount: $800
- Empire pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

Empire BlueCross

Empire BlueCross
Dental Enrollment Department
PO Box 838
Minneapolis MN 55440-0838

Dental Membership Enrollment Form

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E and return form to benefit administrator.

Employee's Name:	Last	First	Middle Initial				**Social Security Number** / /
Gender:	Male ☐	Female ☐	**Marital Status:**	Single ☐	Married ☐	Widowed ☐ Divorced ☐ Legally Separated ☐	**Date of Birth (Month-Day-Year)** / /
Employee's Address:	Address			Home Phone Number		Work Phone Number	
	City		State		Zip Code		

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):

☐ Employee Only*
☐ Employee and Spouse
☐ Employee and Dependent Child(ren)
☐ Family
☐ No Coverage*

* **If waiving coverage for employee and/or any eligible family members, you must complete Part D.**

Complete If Multiple Plan Options Are Offered

I elect to participate in the following Plan:
☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D

PART C – DEPENDENT INFORMATION

Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year	Full Time Student?		Unmarried?	
Spouse		M	F	/ /				
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N

PART D – EMPLOYEE SIGNATURE – Select One

Do you (the employee) have other dental coverage? ☐ Yes ☐ No Do your dependents have other dental coverage? ☐ Yes ☐ No
Name of Carrier: _____ Policy/Identification Number: _____

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Empire BlueCross reserves the right to decline any further dental enrollment changes.

Employee Signature: **Date:**

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. I have read, or have had read to me, the completed application and I realize 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

Employee Signature: **Date:**

PART E – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ **New Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Coverage Effective Date: _____/_____/_____

☐ **Existing Dental Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Coverage Effective Date: _____/_____/_____

☐ **Rehire** Date Lay Off Began: _____/_____/_____
Date Rehired: _____/_____/_____

☐ **Return from Leave of Absence**
Date Leave Began: _____/_____/_____
Date Returned to Work: _____/_____/_____

☐ **Employee Change Part Time to Full Time**
Date of Status Change: _____/_____/_____
Effective Date: _____/_____/_____

☐ **New Hire** – Apply Probationary Period (if applicable) to determine Effective Date
Hire Date: _____/_____/_____
Effective Date: _____/_____/_____

☐ **Open Enrollment**
Effective Date:
_____/_____/_____

☐ **Previously Waived Coverage or Loss of Coverage**
Qualifying Event Reason: _____
Hire Date: _____/_____/_____
Event Date: _____/_____/_____
Effective Date: _____/_____/_____

Group Name: **Group & Subgroup Numbers**:

Group Representative's Signature: **Date:** **Phone Number:** ( )

Blue View Vision℠

Whether you wear glasses, contacts or neither, vision care is an important part of your overall health. Routine eye exams help protect your eye sight and can help detect other health problems, as well. Blue View Vision helps you get the vision care you need — without breaking your budget.

Here are some reasons to choose Blue View Vision:

- **You have access to eye doctors close to you.**
  The Blue View Vision network has more than 30,000 eye doctors and more than 25,000 locations. It includes national retail stores like LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical, most Pearle Vision® locations and New York-based Empire and Davis Vision stores. If you don't already have a favorite, you can quickly find one online at **empireblue.com**.

  If you use an eye doctor who's not in the network, you're still covered. You'll be asked to pay the full cost of the services you receive at your visit. Then mail your receipt and paperwork to us and we'll pay you back for what the plan covers. To get a claim form, go to **empireblue.com**. But you'll save time and money by using an eye doctor or retail store that's in the network.
- **You'll get some great in-network benefits.**
  Blue View Vision plans cover things like factory scratch coating on standard/basic eyeglass lenses at no extra cost. And children under age 19 can get UV blocking Transitions® lenses and impact-resistant polycarbonate lenses at no extra charge.
- **It's simple to use your plan.**
  Just make an appointment with an in-network eye doctor and show your member ID card when you arrive.[1] If you don't have your member ID card, don't worry. They can look up your ID number online if they're part of the Blue View Vision network.
- **You save even more with extra discounts from in-network providers.**
  Want an eyeglass frame that costs more than your plan covers? You'll save 20% off the balance.[2] Want extra pairs of glasses, conventional contact lenses or prescription sunglasses? You'll save 15% to 40% on those. Plus, these discounts are unlimited and are in addition to your benefits for the coverage period.
- **You'll get support after normal business hours.**
  Because you may see your eye doctor at night or on weekends, we're open to help you at those times, too.

Blue View Vision makes it easy and convenient to get vision care when you need it. And the extra discounts we offer help make it even more affordable for you. Thanks for considering us.

Keep in mind this is a brief overview of the plan's features. Your Summary of Benefits contains the details. See your benefits manager if you need a copy.

1 Selecting out of network providers will result in higher costs to you. Make sure the provider you select is in-network to maximize your benefits.

2 Discounts do not apply on frames for which a manufacturer has imposed a no discount policy.

WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!

Blue View Vision℠ BV B 10.10 130/130

Your Blue View Vision network

Empire Blue Cross vision members have access to one of the nation's largest vision networks. Blue View Vision is the only vision plan that gives members the ability to use their in-network benefits at 1-800 CONTACTS, or choose a private practice eye doctor, or go in store to LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical, most Pearle Vision® locations, and New York based Empire Vision and Davis Vision Centers.

Out-of-network: If you choose to, you may receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Routine eye exam once every 12 months	$10 copay	$40 allowance
Eyeglass frames Once every 24 months you may select an eyeglass frame and receive an allowance toward the purchase price	$130 allowance, then 20% off any remaining balance	$45 allowance
Eyeglass lenses *(Standard)* Once every 12 months you may receive any one of the following lens options:		
• Standard plastic single vision lenses *(1 pair)*	$10 copay	$25 allowance
• Standard plastic bifocal lenses *(1 pair)*	$10 copay	$40 allowance
• Standard plastic trifocal lenses *(1 pair)*	$10 copay	$55 allowance
Eyeglass lens enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.		
• Transitions Lenses (for a child under age 19)	$0 copay	No allowance on lens enhancements when obtained out-of-network
• Standard Polycarbonate (for a child under age 19)	$0 copay	
• Factory Scratch Coating	$0 copay	
Contact lenses – once every 12 months		
Prefer contact lenses over glasses? You may choose contact lenses instead of eyeglass lenses and receive an allowance toward the cost of a supply of contact lenses.		
• Elective Conventional Lenses; or	$130 allowance, then 15% off any remaining balance	$105 allowance
• Elective Disposable Lenses; or	$130 allowance *(no additional discount)*	$105 allowance
• Non-Elective Contact Lenses	Covered in full	$210 allowance

Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.

BLUE VIEW VISION MEMBER EXCLUSIVE!

You may use your <u>in-network</u> benefit to order your contact lenses from 1-800 CONTACTS.
1-800 CONTACTS offers a huge in-stock inventory, unbeatable prices, outstanding customer service and free shipping.
Just call 1-800 CONTACTS or go to 1800contacts.com for fast and easy ordering of your contact lenses.

EXCLUSIONS & LIMITATIONS (not a comprehensive list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.

OPTIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	○ Transitions lenses (Adults)
	○ Standard Polycarbonate (Adults)
	○ Tint (Solid and Gradient)
	○ UV Coating
	○ Progressive Lenses[1]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	  ○ Premium Tier 3
	○ Anti-Reflective Coating[2]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	○ Other Add-ons and Services
		$75
		$40
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	○ Complete Pair ○ Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	○ Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	○ Standard contact lens fitting[3] ○ Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	○ Discount applies to materials only	15% off retail price
SOME OF THE ADDITIONAL SAVINGS AVAILBLE THROUGH OUR SPECIAL OFFERS PROGRAM		
1800 CONTACTS After your benefits for the coverage period have been used, you can save on contact lenses with this offer.[5]	○ For this and other great offers, login to member services, select discounts, then Vision, Hearing & Dental	Save $20 on orders of $100 or more and get free shipping
Laser vision correction surgery LASIK refractive surgery.	○ For this offer and more like it, login to member services, select discounts, then Vision, Hearing & Dental	Discount per eye

[1] Please ask your provider for his/her recommendation as well as the progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the coating brands by tier.

[3] A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

[5] Discount cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose an out-of-network provider, please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. When visiting an out-of-network provider, discounts do not apply and you are responsible for payment of services and/or eyewear materials at the time of service.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit empireblue.com or call us at 1-866-723-0515.

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. Discounts referenced are not covered benefits under this vision plan and therefore are not included in the member's policy. Laws in some states may prohibit network providers from discounting products and services that are not covered benefits under the plan. Frame discounts may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Discounts are subject to change without notice. This benefit overview is only one piece of your entire enrollment package.

Health, Wellness & Empire Advantages

Your Empire plan has so much to offer, you won't want to miss a thing.

Register at empireblue.com today!

To learn about all the great tools on empireblue.com go to empireblue.com/bc/guidedtour

Understanding your health plan just got a whole lot easier.

Your health; what's more important? So shouldn't understanding your health plan be just as important? We think so. So we made it easier, with empireblue.com.

Once you register, you'll see how empireblue.com makes complex information easy to understand and easy to use. You'll be able to know what's covered and what's not, what your costs will be for procedures, prescription drugs, doctor visits and so much more. Not only that, you can also save money and live better with our online tools that keep you informed, in control and at your healthy best. Take a look at all you can do:

Get an idea of what your costs will be before you go

Did you know that different hospitals and facilities charge different amounts for the same services? Now you can know your cost before you set foot in the hospital by going to empireblue.com. By getting an estimate of your costs based on the benefits of your health plan, you can choose a facility that fits your budget.

Get members' only discounts on health-related products and services through SpecialOffers

Enjoy discounts such as 20% savings on vitamins and supplements. Save $20 with a minimum purchase of $100, plus free shipping and free returns at 1-800 CONTACTS and Glasses.com. Get more from your membership by exploring over 50 discounts available to you.

Isn't it time your life got a little easier. If you're not already registered at empireblue.com, why not do it now? It's fast, secure and oh so easy!

360° Health® programs

Options. Extras. Support. Helping you improve your health and wellness.

Your health goals and needs are as unique as you are. What's right for one person is not always right for another. Maybe you're managing a health condition. Or maybe you want to stay healthy, eat better or get in shape. Whatever your needs, Anthem gives you a choice of programs to help you meet your personal goals in a way that fits you and helps you live your life to the fullest. From tips and tools to help you learn about preventive care to nurses who can answer your health questions anytime, 360° Health can help you take better control over your health. And it can give you the power to make the decisions that are right for you.

To learn more about 360° Health, go to empireblue.com. Look under Health and Wellness. Here are programs we offer:

24/7 NurseLine

Round-the-clock access to health information can really help your peace of mind and your physical well-being. That's why we have registered nurses ready to speak with you about your general health issues any time of the day or night. Just call the 24/7 NurseLine toll-free number to get answers to questions like these:

- Can the problem be treated at home?
- Do you need to see your doctor?
- Should you go to the emergency room or urgent care for this? Where is the nearest one?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, it can help safeguard your health and the health of your family. To learn more visit empireblue.com/bc/nurseline_video.

To reach 24/7 NurseLine, just call the customer service number on your ID card and ask to speak to a 24/7 NurseLine representative.

Future Moms

If you are pregnant, we know your goal is to have a safe delivery and a healthy baby. Our Future Moms program helps you make healthy choices while you're pregnant and when you deliver your baby. Register for Future Moms and you'll get:

- 24/7 toll-free access to a registered nurse who'll answer your questions and talk to you about pregnancy-related issues. Our nurses will also call to see how you're doing.
- A helpful book: ***Your Pregnancy Week by Week*** and a maternity care diary.
- Tips and facts to help you handle any unexpected events.
- A questionnaire to see if you're at risk for preterm delivery.
- Useful tools to help you, your doctor and your Future Moms nurse track your pregnancy and spot possible risks.

Enroll in Future Moms by calling the customer service number on your ID card. Ask to speak to a Future Moms representative. To learn more visit

360° Health® programs (continued)

empireblue.com/bc/futuremoms_video.

ComplexCare

ComplexCare is for our members with more than one health problem or a condition that puts them at risk for needing more care, more often.

With ComplexCare, you have 24/7 toll-free access to nurses who will work one-on-one with you to teach you about taking care of your condition while living the life you like to live. They'll also help you learn about why it's important to go for regular checkups and screenings. The nurses can help you make better choices about your care. They can also help make sure your doctors all talk to each other about your care and what's best for you. If you qualify for the ComplexCare program, a nurse will contact you.

To learn more, log on to empireblue.com or contact the customer service number on your ID card.

Information You Should Know

Managing your care if you need to go to a hospital or get certain medical treatment

If you or a family member needs certain types of medical care (for example: surgery, treatment in a doctor's office, physical therapy, etc.), you may want to know more about these programs and terms. They may help you better understand your benefits and how your health plan manages these types of care.

Utilization management

Utilization management (UM) is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our UM review team, made up of licensed health care professionals such as nurses and doctors, do medical reviews. The team goes over the information your doctor has sent us to see if the requested surgery, treatment or other type of care is medically needed. The UM review team checks to make sure the treatment meets certain rules set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The UM review team will let you and your doctor know as soon as possible.

We can do medical reviews like this before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before you get medical care)

We may do a prospective review before a member goes to the hospital or has other types of service or treatment. Here are some types of medical needs that might call for a prospective review:

- A hospital visit
- An outpatient procedure
- Tests to find the cause of an illness, like magnetic resonance imaging (MRI) and computed tomography (CT) scans
- Certain types of outpatient therapy, like physical therapy or emotional health counseling
- "Durable medical equipment" (DME), like wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)

We do a concurrent review when you are in the hospital or are released and need more care related to the hospital stay. This could mean services or treatment in a doctor's office, regular office visits, physical or emotional therapy, home health care, durable medical equipment, a stay in a nursing home, emotional health care visits and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

Managing your care if you need to go to a hospital or get certain medical treatment (continued)

The retrospective or post-service review (done after you get medical care)

We do a retrospective review when you have already had surgery or another type of medical care. When the UM review team learns about the treatment, they look at the medical information the doctor or provider had about you at the time the medical care was given. The team then can see if the treatment was medically needed.

Case management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Preauthorization

Preauthorization is the process of getting approval from your health plan before you get services. This process lets you know if we will cover a service, supply, therapy or drug. We approve services that meet our standards for needed and appropriate treatment. The guidelines we use to approve treatment are **based on standards of care in medical policies, clinical guidelines and the terms of your plan**. As these may change, **we review our preauthorization guidelines regularly**. Preauthorization is also called "precertification," "prior authorization," or "pre-approval."

Here's how getting preauthorization can help you out:

Saving time. Preauthorizing services can save a step since you will know if you are eligible and what your benefits are before you get the service. The doctors in our network ask for preauthorization for our members.

Saving money. Paying only for medically necessary services helps everyone save. Choosing a doctor who's in our network can help you get the most for your health care dollar.

What can you do? Choose an in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need preauthorization or call us to ask. The doctor's office will ask for preauthorization for you. Plus, costs are usually lower with in-network doctors.

If you choose an out-of-network provider, be sure to call us to see if you need preauthorization. Non-network providers may not do that for you. If you ever have a question about whether you need preauthorization, just call the preauthorization or precertification phone number on your ID card.

There are times when we may need to do a benefit review for a health care service you plan to receive or have already received. We do this to find out what your plan will cover for that service. During the review, we take a look at the terms, benefits, limitations and exclusions of your particular plan. This means we may check to see if your plan covers the service, if you've already reached a benefit limit for the service, and if you can see a provider outside of the network. We may also review other aspects of your plan.

Your rights and responsibilities as a member

As a member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
  - Your health care plan
  - Any care you get
  - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

Your rights and responsibilities as a member (continued)

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your "Subscriber Agreement".

Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act explains your rights for treatment under the health plans if you need a mastectomy. Plain and simple... we're here for you.

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Empire BlueCross benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.
- All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance.

HIPAA NOTICE OF PRIVACY PRACTICES

The HIPAA Notice of Privacy Practices explains the rules around how we handle your private information under HIPAA laws. Plain and simple... we don't share your information unless it's needed to manage your benefits or you give us the OK to do it.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your

Important legal information you should take time to read (continued)

dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Important legal information you should take time to read (continued)

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people, who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Important legal information you should take time to read

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

This Notice is provided by the following company: **Empire BlueCross**

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

Don’t skip this section!

This notice explains when you and your dependents not covered by Empire have the right to enroll on a special basis.

Your special enrollment rights

If you choose not to enroll in an Empire health plan, there are special times when you and your eligible dependents can do so.

If you decline to enroll yourself or your dependents (including your spouse) because you have other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan at a later time. This would occur if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other health coverage). However, you must request enrollment within 60 days after you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

Examples

Example 1 — Loss of other coverage: You and your family are enrolled through your spouse’s coverage at work. Your spouse’s employer stops paying for coverage. In this case, you and your spouse, as well as other dependents on your policy, may be eligible to enroll in one of our health plans.

Example 2 — You have a new dependent: You get married. You and your spouse and any other new dependents may be eligible to enroll in the plan.

You have 60 days to enroll

In each case, you may apply for enrollment with us within 60 days after:

- The other coverage ends.
- The employer stops contributing toward the other coverage.
- The marriage, birth, adoption or placement for adoption.

Enrollment/Change Form

Empire BlueCross

Thank you for choosing Empire. So that we may quickly and accurately process your enrollment, please complete in full and sign in Section 7.

SECTION 1: REASON FOR ENROLLMENT/CHANGE – Please complete section A, B or C

A. NEW ENROLLMENT/ADDITION – Choose only one reason in bold

Date of change (MMDDYY)

☐ **New hire** Applicants in companies with 50 or fewer employees must submit NYS-45, payroll records or W-4 forms to establish employment.

☐ **Open enrollment**

☐ **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 ☐ End stage renal disease

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)

☐ **Right of Election for adult dependents eligible for coverage to age 30 under NYS law**

☐ **Mandatory Right of Election - NYS Qualified dependents only**

☐ **COBRA/NYS Continuation of coverage** Nature of COBRA/NYS event

☐ **Other**

B. CHANGE – Check all that apply. For all checked boxes below, please supply new information in Sections 3 and 4.

Date of change (MMDDYY)

☐ Name ☐ Address ☐ Primary Care Physician (PCP) (HMO/Direct HMO/Direct POS/Empire POS plans only)

☐ Managed Dental Primary Care Dentist (PCD) (If your company offers an Empire Dental plan)

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 4.

Spouse/Dependent ☐ Death ☐ Divorce ☐ Dependent no longer eligible ☐ Other

Date of event (MMDDYY)

SECTION 2: BENEFITS SELECTION

Medical Insurance [1] Select only one plan type:

- ☐ Direct HMO
- ☐ HMO
- ☐ Empire Total Blue℠ Choice (HSA)
- ☐ Empire Prism℠ EPO

Large group plans only

- ☐ EPO ☐ PPO
- ☐ DPOS ☐ DSPOS
- ☐ Empire Total Blue℠ Choice (HRA)
- ☐ Empire Prism℠ PPO

Small group plans only

- ☐ Value EPO ☐ Empire PPO Plus
- ☐ Empire POS ☐ Empire EPO Stepped
- ☐ Empire PPO ☐ Empire EPO Essential
- ☐ Healthy New York

Indemnity Select only one coverage type: ☐ Hospital/Medical ☐ Individual **or** ☐ Hospital Only ☐ Employee/Spouse ☐ Other ☐ Parent/Child(ren) ☐ Family

Dental Insurance [2] Select only one coverage type: ☐ PPO Dental ☐ Individual ☐ Managed Dental ☐ Employee/Spouse ☐ Voluntary Dental ☐ Parent/Child(ren) ☐ Other dental ☐ Family

Vision Insurance [3] **Blue View Vision℠** Select only one coverage type: ☐ Individual ☐ Employee/Spouse ☐ Parent/Child(ren) ☐ Family

[1] Empire will facilitate the opening of a Health Savings Account in your name, as directed by your Employer. [2] If your company offers an Empire Dental Plan. [3] If your company offers a Blue View Vision plan.

SECTION 3: APPLICANT INFORMATION

Last name	First name	M.I.	Social Security no.

Sex ☐ M ☐ F	Birthdate (MMDDYY)	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Marriage date (MMDDYY)	Enter state and country where married [4] →	State	Country

Street address	Apt. no.	Home phone no.

City	State	ZIP code	Daytime phone no.

Occupation	Primary language

E-mail address (requested for ages 18 and over)	☐ Yes, information may be sent to me electronically.	If you, your spouse, and/or dependents are Medicare eligible, please complete section 6.

[4] Marriage must have been entered into in a jurisdiction that recognizes its validity.

SECTION 4: APPLICANT AND FAMILY INFORMATION – Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

Note: If you've chosen HMO/Direct HMO/Direct POS/Empire POS/DirectShare POS, please provide a primary care physician (PCP) for yourself and for each dependent. Please note that no out-of-network benefits are available to HMO/Direct HMO members except for emergency care. If you've chosen Managed Dental, please provide one Primary Care Dentist (PCD) for you and your dependents.

APPLICANT

Primary care physician (PCP) last name	Primary care physician (PCP) first name	PCP no.	Current patient of PCP? ☐ Yes ☐ No
Primary care dentist (PCD) last name	Primary care dentist (PCD) first name	PCD no.	Current patient of PCD? ☐ Yes ☐ No

☐ **SPOUSE** ☐ **DOMESTIC PARTNER**

Last name	First name	M.I.	Social Security no.

Sex ☐ M ☐ F	Birthdate (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.	Current patient of PCP? ☐ Yes ☐ No

E-mail address (requested for ages 18 and over)	☐ Yes, information may be sent to me electronically.

DEPENDENT 1

Last name	First name	M.I.	Social Security no.

Sex ☐ M ☐ F	Married? ☐ Yes ☐ No	Birthdate (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.	Current patient of PCP? ☐ Yes ☐ No

E-mail address (requested for ages 18 and over)	☐ Yes, information may be sent to me electronically.

Relationship: ☐ Child ☐ Full-time student[5] ☐ Disabled child[6] ☐ Make available age 29 adult dependent child

DEPENDENT 2

Last name	First name	M.I.	Social Security no.

Sex ☐ M ☐ F	Married? ☐ Yes ☐ No	Birthdate (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.	Current patient of PCP? ☐ Yes ☐ No

E-mail address (requested for ages 18 and over)	☐ Yes, information may be sent to me electronically.

Relationship: ☐ Child ☐ Full-time student[5] ☐ Disabled child[6] ☐ Make available age 29 adult dependent child

DEPENDENT 3

Last name	First name	M.I.	Social Security no.

Sex ☐ M ☐ F	Married? ☐ Yes ☐ No	Birthdate (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.	Current patient of PCP? ☐ Yes ☐ No

E-mail address (requested for ages 18 and over)	☐ Yes, information may be sent to me electronically.

Relationship: ☐ Child ☐ Full-time student[5] ☐ Disabled child[6] ☐ Make available age 29 adult dependent child

[5] Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
[6] Please submit Request for Disabled Child form (HAC506) with this form; child age must exceed contractual dependent age.

SECTION 5: OTHER COVERAGE INFORMATION – This section must be completed

Do you, or your family members, currently have, or have had, health insurance in the past 11 months?
☐ Yes ☐ No **If yes, please complete the following:**

Name(s) of person(s) (first, M.I., last)	Insurance company information	Date coverage	Provided by employer?	Employment status	Contract type
Self	Name Phone Certificate (policy no.)	Began Ended	☐ Yes ☐ No	☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
☐ Spouse ☐ Domestic Partner	Name Phone Certificate (policy no.)	Began Ended	☐ Yes ☐ No	☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 1	Name Phone Certificate (policy no.)	Began Ended	☐ Yes ☐ No	☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 2	Name Phone Certificate (policy no.)	Began Ended	☐ Yes ☐ No	☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 3	Name Phone Certificate (policy no.)	Began Ended	☐ Yes ☐ No	☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)

SECTION 6: MEDICARE INFORMATION – For Medicare eligible only

Please provide a copy of the Medicare (HIB) card for each person listed below. If copies are not attached, we cannot process your Medicare benefits request.

APPLICANT

Medicare ID no.	HIB Suffix	Part A coverage start date	Part B coverage start date

SPOUSE

Medicare ID no.	HIB Suffix	Part A coverage start date	Part B coverage start date

DEPENDENT

Dependent name	Medicare ID no.	HIB Suffix	Part A coverage start date	Part B coverage start date

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

SECTION 7: APPLICANT SIGNATURE – I have read the Certification and Insurance Fraud Statement below.

Certification: I certify that 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. 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 and that failure to make such notification may result in cancellation of the coverage by Empire. Any other Empire coverage will end upon issuance of this coverage. If I do not agree to transfer my other coverage with Empire to this coverage, I understand that this application will not be accepted by Empire.

I authorize any health care provider, health care payor or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for use by Empire to administer the terms of my health benefits contract. I also authorize Empire to disclose such information to an Empire designee, my PCP and other providers, other payors, and the group contract holder, for purposes of continuity of care and medical management, disease management, health benefits contract administration, financial audits, and as otherwise required by law. The foregoing authorizations are valid for a maximum period of 24 months. All statements and answers in this notice of election are true and are representations made to induce the issuance of the coverage. Any material misrepresentation may result in Empire's cancellation of coverage.

Insurance Fraud Statement: 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 **X**	Print name	Date (MMDDYY)

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 FT employment start date

Authorized Group Benefits Administrator signature **X**	Print name	Date (MMDDYY)

Empire BlueCross

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HIPAA Individual Authorization

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.

Empire BlueCross
ATTENTION: Customer Service
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

INSTRUCTIONS:

Please complete the following information exactly as it appears on your member Identification (ID) Card. Complete the form in its entirety and include as much information as possible. If necessary, call the number listed on your member ID card for assistance.

Individual Last Name	**Individual First Name**	**Middle Initial**	**Group ID No.**
Individual ID No. (From Member ID Card)	**Social Security Number** (optional)	**Date of Birth** (MM/DD/YYYY)	**Daytime Telephone** (with Area Code)
Individual Street Address	**City**	**State**	**Zip Code**

Part A: I authorize the following person or types of people to disclose my information:

Empire BlueCross and its affiliates and agents.

Part B: I authorize the following person or types of people to receive my information (the person receiving the information must be 18 years of age or older):

Relationship to the individual _____

Part C: I authorize the following information to be used or disclosed on my behalf (check one block):

☐ **All my information** including health (e.g. diagnosis, claims, provider) and financial information (e.g. premium information, checking account) may be disclosed

OR

☐ **Only limited information** may be disclosed (check all applicable blocks below)

Limited Information

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Diagnosis and procedure
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records (excludes psychotherapy notes*)
- ☐ Physician and hospital
- ☐ Pre-certification and pre-authorization
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Mental health
- ☐ Other: _____

I authorize the release of the following types of sensitive information (check all blocks that apply):

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted or other communicable diseases
- ☐ Other: _____

Part D: The purpose of my authorization is (check one block):

☐ To disclose the information at my request

☐ For the following purposes: _____

Part E: Expiration Date. If not previously revoked, this authorization will terminate on the earliest of the following dates

- The date my coverage ends (only if disclosure requested by insurance company); or
- One year from the signature date below; or
- upon the following date, event or condition (within the one year time frame): _____

Part F: I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above. I also understand this authorization is voluntary and that the person listed in Part A will not condition my treatment, payment, or enrollment or eligibility for benefits on signing this authorization.

I have the right to revoke this authorization at any time by giving written notice of my revocation to the person listed in Part A. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that information disclosed may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this authorization.

Individual signature _____ **Date** _____

Designated Legal Representative / Guardian

If this form is signed by a legal representative/guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf must be attached.

Legal representative (print full name): _____

Legal relationship to individual: _____

Signature _____ Date: _____

*Note: This form cannot be used for psychotherapy notes. If you seek to authorize the use or disclosure of psychotherapy notes, then you will need to do so using a separate form.

Please keep a copy of this form for your records and return the completed form to:

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

Once you're a member, it's easy to get answers to any questions about your plan.

Just call the number on the back of your member identification (ID) card after you get it.

Empire BlueCross