Empire BlueCross BlueShield

An Anthem Company

For more information, visit our website at **www.empireblue.com**.

The person who is discussing plan options with you is either employed by or contracted with Empire BlueCross BlueShield. The person may be compensated based on your enrollment in a plan.

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

ANSF458M(18)-NY BCBS

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Empire BlueCross BlueShield

An Anthem Company

Your Guide to Enrolling

Medicare Supplement
Empire BlueCross BlueShield New York 2018

Plans A, B, F, G and N (Effective July 1, 2018)

Empire BlueCross BlueShield

An Anthem Company

Thank you for your interest in a Medicare Supplement plan from Empire BlueCross BlueShield.

We understand that Original Medicare can be overwhelming – our objective is to make this process as simple and straightforward as possible. With a Medicare Supplement plan from Empire BlueCross BlueShield, you can have peace of mind knowing you have coverage from a trusted company to help fill the gaps with Original Medicare. To learn more about our plans, keep reading this brochure. There is also helpful contact information at the back of this brochure.

What's Inside:

AADVBR013M(17)-NY BCBS

69925NYSENMUB_NYBCBS_G (Rev. 05/2018)

Don’t miss out on a chance to SAVE money!

- Pay by Automatic Bank Draft or Annual Payment Option
  - **SAVE $2 off your monthly premium** by paying by Auto Bank Draft or Electronic Funds Transfer (EFT); or
  - **SAVE $48 by paying your premium for the entire year.** (The discount maybe prorated the first year depending on the policy effective date.)

Understanding how Medicare works

Original Medicare Part A is hospital coverage that helps cover the costs for:

- Inpatient care in a hospital or skilled nursing facility (not custodial or long-term care).
- Hospice and some home health care services.

Original Medicare Part B is medical coverage that helps cover the costs for:

- Doctor services, hospital outpatient care and some home health care services, as well as lab tests and durable medical equipment.
- Most preventive services, including an annual wellness exam.

Medicare Part C, also called Medicare Advantage:

- Replaces Original Medicare Parts A and B.
- Provided by private health insurance companies.
- Requires annual enrollment.
- May have a provider/facility network.

Medicare Part D is stand-alone prescription drug coverage and:

- Helps pay for many brand-name and generic prescribed drugs.
- Gives you access to mail-order options and retail drugstores across the country.

Importance of a Medicare Supplement plan

Medicare Supplement plans bridge the "gap" in costs that are not fully covered by Original Medicare, such as:

- Medicare Part A or Part B deductibles, coinsurance or copayments.
- Medicare Part B excess charges.
- Skilled Nursing Facility care coinsurance.
- Foreign Travel Emergencies.

Have peace of mind knowing the coverage "gaps" are filled.

- Original Medicare has substantial deductibles and copayments that are your responsibility. This means you can easily spend thousands of dollars each year on medical costs (known as the "donut hole") that are not fully covered by Original Medicare.

Other reasons to consider a Medicare Supplement plan:

- **Financial security:** Based on the plan you enroll in, it provides coverage for "gaps" in Original Medicare, helping you safeguard your retirement savings.
- **Guaranteed renewable:**[1] Once you enroll, **you can keep your plan for life — no annual enrollment!**
- **Portability:** If you move, your Medicare Supplement plan moves with you.
- **Freedom to choose:** No referrals, and you can **go to any** Medicare provider who is accepting new patients.
- **Plan benefits won't change:** Plans only change to keep pace with Original Medicare — to keep those "gaps" filled!

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1 Once enrolled into your Medicare Supplement insurance plan, your coverage is guaranteed for the life of the plan with only two exceptions/restrictions: nonpayment of premiums and material misrepresentation.

Plan options to meet your needs

Now that you're well informed about the benefits of having a Medicare Supplement plan, it's time to consider the type of plan you may need. The next page features our available plans with varying coverage levels to meet your needs.

Benefits	Amount Medicare Pays[1]	Amount Medicare Supplement Plan Pays				
		Plan A	Plan B	Plan F	Plan G	Plan N[2]
▼ Part A: Hospitalization						
First 60 days (Part A Deductible)	All but $1,340	$0	$1,340	$1,340	$1,340	$1,340
61st – 90th day	All but $335 a day	$335 a day	$335 a day	$335 a day	$335 a day	$335 a day
91st day and after	All but $670 a day	$670 a day	$670 a day	$670 a day	$670 a day	$670 a day
▼ Skilled Nursing Facility						
First 20 days	All approved amounts	$0	$0	$0	$0	$0
21st – 100th day	All but $167.50 a day	$0	$0	Up to $167.50 a day	Up to $167.50 a day	Up to $167.50 a day
101st day and after	$0	$0	$0	$0	$0	$0
▼ Part B: Medical Expenses						
Medicare Part B Deductible	All but $183	$0	$0	$183	$0	$0
Medicare Part B Excess Charges[3]	$0	$0	$0	100%	100%	$0
▼ Other Benefits						
Foreign Travel Emergency	$0	$0	$0	80%[4]	80%[4]	80%[4]

See *Outline of Coverage* for more details.

1 The amount Medicare pays of the Medicare-approved amount. Original Medicare deductibles, premiums and coinsurance rates are effective January 1 of every year, based on the Consumer Price Index.

2 Pays 100% of Part B coinsurance, except for copay up to $20 for office visits and up to $50 copay for emergency room visits that do not result in an inpatient admission.

3 If you have Original Medicare and the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount, the difference is called the excess charge. New York limits the amount that Medicare non-participating providers can charge over the Medicare-approved amount to 5% over the Medicare-approved amount.

4 Pays 80% of the Medicare-approved amount and up to a lifetime maximum benefit of $50,000 after you pay the annual deductible of $250.

Protecting yourself — covering the gaps in Original Medicare

- As you can see from the chart on the previous page, different Medicare Supplement plans cover different types of medical costs. Let's take a closer look at your out-of-pocket costs with Original Medicare only, and if you have **Medicare Supplement Plan F or Plan G**.
- **Example:** You are covered by Original Medicare when you are unexpectedly hospitalized and have major surgery. After a 15-day stay in the hospital, followed by 22 days in a Skilled Nursing Facility, you learn the physician does not accept the Medicare-approved amount (Medicare Assignment). As a result, you are responsible for the 20% not covered by your Part B coinsurance and the physician's excess[3] charge up to 5% over the Medicare-approved amount. Let's compare your out-of-pocket costs with Original Medicare only, and then if you had purchased Medicare Supplement Plan F or Plan G. For illustrative purposes, the amount remaining after Medicare has paid the 80% under Medicare Part B is $12,000. You would be responsible for $2,400, which is 20% of the $12,000. In addition, since the provider does not accept Medicare as payment in full, we will assume the excess charges are $600.

Benefits	Out-of-Pocket Costs		
	Original Medicare Only	Medicare Supplement Plan F	Medicare Supplement Plan G
Medicare Part A deductible for 15 days of hospitalization	$1,340[1]	$0	$0
Medicare Part A coinsurance for 22 days in Skilled Nursing Facility[2] ($167.50/day for days 21-100) (2 days x $167.50)	$335	$0	$0
Medicare Part B deductible	$183	$0	$183
Medicare Part B coinsurance for surgical services, supplies, lab tests and therapy (20% cost share of Medicare-approved amount = $12,000)	$2,400	$0	$0
Medicare Part B Excess[3] amounts above what provider has agreed to accept based on Medicare's approved amount $600 for illustrative purposes	$600	$0	$0
Your total out-of-pocket costs	**$4,858**	**$0**	**$183**

(Your out-of-pocket amounts would vary with other plans.)

1 Deductible covers first 60 days for extended in-patient stays. You may incur a per-day fee under Original Medicare. The deductible is based on a benefit period that begins on the first day you receive inpatient services and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
2 Original Medicare covers the first 20 days.
3 Excess charges are limited to 5% in New York.

Get fit and be healthy with SilverSneakers®

We offer **Tivity Health SilverSneakers**[1] as a value-added fitness program at no cost to you. Once you enroll, you can sign up for SilverSneakers. Your SilverSneakers membership includes:

- Access to more than 13,000 fitness locations.
- All basic amenities, services and programs at participating locations nationwide.
- If you're unable to get to a fitness location, you can select a fitness kit that you can use at home or on the go when you sign up for SilverSneakers Steps.
- Group exercise classes at some sites.
- SilverSneakers FLEX, which includes classes and activities at parks, recreation centers and other local venues.
- Access to a secure, members-only online community.

To find fitness locations, request your unique SilverSneakers ID number, enroll in FLEX classes or get additional details, visit **www.silversneakers.com**, or call SilverSneakers Customer Service at **1-855-741-4985** (TTY: **711**), Monday through Friday, 8 a.m. to 8 p.m. ET.

SilverSneakers® by Tivity Health

1 Please check with your doctor before you start a physical activity program. SilverSneakers is a value-added program. It is not insurance and not part of the Medicare Supplement insurance plans. It can be changed or withdrawn at any time. The SilverSneakers fitness program is provided by Tivity Health, an independent company. Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries.

Enrolling

Enroll now

Once you enroll in Medicare Part B, you can enroll into a Medicare Supplement policy at any time during the year. To get started, just follow these steps:

1. Select the plan that best fits your needs.
2. Complete all sections on the Enrollment application.
3. Select your desired payment option. (Your options are listed on the application.)
4. Complete and return the Premium Payment Form to sign up for Automatic Bank Draft and save $2 on your monthly premium.
5. Sign and date the application and return it with any additional forms or documents.
6. Be sure to make a copy of your application for your records.

Your agent can help you fill out the application and answer any questions you may have about adding additional benefits, if available.

How to reach us

Sales Department[1] **1-888-849-2420**
TTY line **711**
8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30

Customer Service **1-844-395-1026**
TTY line **711**
8:00 a.m. to 6:00 p.m. ET Monday – Friday

Online benefits, discounts and health resources ..... **www.empireblue.com**
- Find a doctor
- Enroll online
- Find a pharmacy
- Find your covered drugs

General information about Medicare ..... **www.medicare.gov**

In case of emergency, call 911.
TTY lines are for those with hearing or speech loss.

1 By calling this number, you will reach an authorized licensed insurance agent who can answer questions about our plans and enrollment.

Empire BlueCross BlueShield

An Anthem Company

This brochure is intended to be a brief summary of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Policy. In the event of a conflict between the Policy and this description, the terms of the Policy will prevail.

Not connected with or endorsed by the U.S. Government or the federal Medicare program. The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent or insurance company.

This policy has exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, please contact your agent or the health plan.

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

It's important we treat you fairly
That's why we follow Federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call Customer Service for help (TTY: 711).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, 4361 Irwin Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040-9498. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling
1-800-368-1019 (TTY: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Get help in your language
Separate from our language assistance program, we make documents available in alternate formats. If you need a copy of this document in an alternate format, please call Customer Service.

English: You have the right to get this information and help in your language for free. Call Customer Service for help.

Spanish: Tiene el derecho de obtener esta información y ayuda en su idioma de forma gratuita. Llame al número de Servicios para Miembros para obtener ayuda.

Albanian: Keni të drejtën të merrni falas këtë informacion dhe ndihmë në gjuhën tuaj. Telefononi shërbimin për klientët nëqoftëse keni nevojë për ndihmë.

Arabic:
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل بخدمة العملاء للمساعدة.

Bengali: এই তথ্যাবলি পাওয়ার বিষয়ে এবং বিনামূল্যে আপনার ভাষায় সহযোগিতা পাওয়ার অধিকার আপনার আছে। সাহায্যের জন্য কাস্টমার সার্ভিসে কল করুন।

Chinese: 您有權使用您的語言免費獲得該資訊和協助。請致電客戶服務部尋求協助。

French: Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour obtenir de l'aide, veuillez appeler le service client.

Greek: Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτή τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε το Τμήμα Υπηρεσιών Πελατών (Customer Service) για βοήθεια.

Haitian: Ou gen dwa resevwa enfòmasyon sa a ak asistans nan lang ou pale a pou gratis. Rele nimewo Sèvis Kliyan an pou jwenn èd.

Italian: Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il Servizio clienti.

Korean: 귀하께는 본 정보와 도움을 비용없이 귀하의 언어로 받으실 권리가 있습니다. 도움을 받으시려면 고객 서비스부로 연락해 주십시오.

Polish: Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. Zadzwoń pod numer Działu Obsługi Klienta w celu uzyskania pomocy.

Russian: Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания клиентов.

Tagalog: May karapatan kang makuha ang impormasyon at tulong na ito sa sarili mong wika ng walang kabayaran. Tumawag sa Serbisyo para sa mga Kustomer para matulungan ka.

Urdu:

آپ کو اپنی زبان میں یہ معلومات اور مدد مفت حاصل کرنے کا حق ہے۔ مدد کے لیے کسٹمر سروس کو کال کریں۔

Yiddish:

איר האט די רעכט צו באקומען די אינפארמאציע און הילף אין אייער שפראך בחינם. רופט קאסטומער סערוויס פאר הילף.

Outline of Coverage

An easy-to-read overview of your benefit options.

WPNSF190M(Rev. 6/16)

Empire BlueCross BlueShield

An Anthem Company

Medicare Supplement Outline of Coverage

Plans A, B, F, G & N

Empire BlueCross BlueShield New York 2018

This booklet includes premium rates, Medicare deductibles, copays and maximum out-of-pocket costs.

Call toll-free 1-888-849-2420 with questions.
Administrative Office: P.O. Box 659816, San Antonio, TX 78265-9116

AOOC004M(17)-NY BCBS

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plans "A and B" available and either "C" or "F". Some plans may not be available in your state. Plans shown in gray are available for purchase.

These same Plans are available to those who are under 65 and qualify for Medicare due to disability.

Basic Benefits

- **Hospitalization –** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses –** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood –** First three pints of blood each year.
- **Hospice –** Part A coinsurance.

Benefits	A	B	C	D	F | F*[1]	G	K	L	M	N
Basic Coverage, Including 100% Part B Coinsurance	✓	✓	✓	✓	✓*	✓			✓	✓▲
Hospitalization & Preventative Care /Other Basic Benefits							**100**% /**50**%	**100**% /**75**%		
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	**50**%	**75**%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	**50**%	**75**%	**50**%	✓
Part B Deductible			✓		✓					
Part B Excess (100%)					✓	✓				
Foreign Travel Emergency			✓	✓	✓	✓			✓	✓
Out-of-pocket Limit; Paid at 100% after Limit is Reached							**$5,240**	**$2,620**		

* Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,240 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

1 High Deductible Plan F is not available.

▲ Basic benefits, EXCEPT up to $20 copayment for office visit, and up to $50 copayment for emergency room visit.

Premium Information

Plans A, B, F, G & N | Effective July 1, 2018
Premiums are subject to change.

Here's some important information, before we get started:

The following pages are designed to help you determine the premium for the plan you select.

Premiums are subject to change in accordance with the terms of the Policy. Your Premium Billing Preference does not guarantee your premium for any specific time period. Any state-approved premium changes will be applied starting no earlier than 60 days after notification from us, regardless of your Premium Billing Preference. The selected Premium Billing Preference will take effect on the first day of payment period which immediately follows your Coverage Effective Date. For example, if your Coverage Effective Date is September 1 and you pick the Quarterly Premium Billing Preference, Quarterly premium billing will start on October 1; if you select the Annual Premium Billing Preference, Annual premium billing will start on January 1. Any premiums billed for the period of time from your Coverage Effective Date to the start of your selected Premium Billing Preference will be prorated to reflect the Premium Billing Preference selected. We, Empire BlueCross BlueShield, will comply with all premium process notice requirements.

We, Empire BlueCross BlueShield, can only raise your premium if we raise the premium for all plans like yours in this State.

Finding the Right Plan for You

Plans A, B, F, G & N | Effective July 1, 2018
Premiums are subject to change.

Compare Plans

After locating the monthly premium, you are ready to review the individual plan pages. These pages provide details of the covered services and what each plan pays. Based on your individual needs, these pages will help you determine the plan that is best for you. You are now ready to **ENROLL**!

Don't miss out on a chance to SAVE!

These optional discounts are offered for all of the following Premium Tables.

SAVE $2 on your monthly premium!

Enroll in our Automatic Bank Draft or Electronic Fund Transfer (EFT) program and you will save $2 on your monthly premium. (To enroll, simply complete the Premium Payment Form.)

OR

SAVE $48 by paying your premium for the entire year!

(Note: Based on the policy effective date, the discount may be pro-rated the first year.)

Ways to Enroll

Sales Department*
Call 1-888-849-2420
(TTY/TDD: **711**)
8 a.m. to 8 p.m.
seven days a week

Customer Service
Call 1-844-395-1026
(TTY/TDD: **711**)
8:00 a.m. to 6:00 p.m. ET
Monday – Friday

Visit us Online
www.empireblue.com
- Enroll online
- Find a doctor
- Find a pharmacy
- List of covered drugs

Let's Begin

* By calling this number, you will reach an authorized licensed insurance agent who can answer questions about our plans and enrollment.

Finding Your Monthly Premium

Plans A, B, F, G & N | Effective July 1, 2018

Premiums are subject to change. Premium is based upon your age, area and plan.

Find Your Premium

	Plan A	Plan B	Plan F	Plan G	Plan N
New York – Area 1	$179.00	$235.00	$290.00	$260.00	$185.00
Mid-Hudson – Area 2	$141.00	$190.00	$230.00	$210.00	$150.00
Albany – Area 3	$141.00	$190.00	$230.00	$210.00	$150.00

New York – Area 1:

Bronx, Kings, Nassau, New York (Manhattan), Queens, Richmond, Rockland, Suffolk, and Westchester County.

Mid-Hudson – Area 2:

Dutchess, Orange, Putnam, Sullivan and Ulster County.

Albany – Area 3:

Columbia, Delaware, and Greene County.

Important Plan Disclosures

Plans A, B, F, G & N
Retain this outline for your records.

Disclosures

Use this outline to compare benefits and premiums among policies.

Medicare deductibles and coinsurance amounts are effective as of January 1, 2018. Medicare may change their amounts annually.

Read Your Policy Very Carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Empire BlueCross BlueShield.

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to us at our Administrative Office: Empire BlueCross BlueShield, P.O. Box 659816, San Antonio, TX 78265-9116. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

This policy may not fully cover all of your medical costs.

Neither Empire BlueCross BlueShield nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

Complete Answers are Very Important

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Plan A

Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
▼ Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$0	$1,340 (Part A deductible)
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
• Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
▼ Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	$0	Up to $167.50 a day
101st day and after	$0	$0	All costs
▼ Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
▼ Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A

(continued)

Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
▼ **Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment,** such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
▼ **Part B Excess Charges**			
Above Medicare Approved Amounts	$0	$0	All costs
▼ **Blood**			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
▼ **Clinical Laboratory Services**			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

Services	Medicare Pays	Plan Pays	You Pay
▼ **Home Health Care — Medicare Approved Services**			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment:			
— First $183 of Medicare approved amounts*	$0	$0	$183 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan B

Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
▼ Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
• Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
▼ Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	$0	Up to $167.50 a day
101st day and after	$0	$0	All costs
▼ Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
▼ Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan B

(continued)

Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
▼ **Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment,** such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
▼ **Part B Excess Charges**			
Above Medicare Approved Amounts	$0	$0	All costs
▼ **Blood**			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
▼ **Clinical Laboratory Services**			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

Services	Medicare Pays	Plan Pays	You Pay
▼ **Home Health Care — Medicare Approved Services**			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment:			
— First $183 of Medicare approved amounts*	$0	$0	$183 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan F

Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
▼ Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
• Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
▼ Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
▼ Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
▼ Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan F

(continued)

Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
▼ **Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment,** such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
▼ **Part B Excess Charges**			
Above Medicare Approved Amounts	$0	100%	$0
▼ **Blood**			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
▼ **Clinical Laboratory Services**			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

Services	Medicare Pays	Plan Pays	You Pay
▼ **Home Health Care — Medicare Approved Services**			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment:			
— First $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
— Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan F

(continued)

Other Benefits – Not Covered by Medicare

Services	Medicare Pays	Plan Pays	You Pay
▼ **Foreign Travel — Not Covered by Medicare** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan G

Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
• Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan G

(continued)

Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
▼ Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
▼ Part B Excess Charges			
Above Medicare Approved Amounts	$0	100%	$0
▼ Blood			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
▼ Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

Services	Medicare Pays	Plan Pays	You Pay
▼ Home Health Care — Medicare Approved Services			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment:			
— First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan G

(continued)

Other Benefits – Not Covered by Medicare

Services	Medicare Pays	Plan Pays	You Pay
▼ **Foreign Travel — Not Covered by Medicare** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan N

Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
▼ Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
• Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
▼ Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
▼ Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
▼ Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan N

(continued)

Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
▼ **Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment,** such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
▼ **Part B Excess Charges**			
Above Medicare Approved Amounts	$0	$0	All costs
▼ **Blood**			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
▼ **Clinical Laboratory Services**			
Tests for Diagnostic Services	100%	$0	$0

* Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan N

(continued)

Parts A & B Services

Services	Medicare Pays	Plan Pays	You Pay
▼ Home Health Care — Medicare Approved Services			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment:			
— First $183 of Medicare approved amounts*	$0	$0	$183 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

Other Benefits – Not Covered by Medicare

Services	Medicare Pays	Plan Pays	You Pay
▼ Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

* Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

P.O. Box 659816
San Antonio, TX 78265-9116

2018_OOC-NYBCBS (Rev. 05_2018)

Enrollment Application

Use this checklist to make sure you have everything covered.

- ☐ Complete the application in blue or black ink.
- ☐ After you've carefully reviewed the application, please sign, date and mail it.

Empire BlueCross BlueShield
An Anthem Company

IMPORTANT NOTICES TO APPLICANT

PREMIUM PAYMENT GUIDELINES

Empire will accept premium payments made on behalf of an applicant or member from **ONLY** the following:

- Family member related by blood, marriage or adoption;
- Legal Guardian and/or Conservator;
- Powers of Attorney; or
- a Trustee acting on behalf of the member that is a Beneficiary of the Trust.

CANCELATION OF CURRENT COVERAGE

If you are a current Empire BlueCross BlueShield member and enrolling in a Medicare Supplement policy and have dependents that need to retain current coverage, please call the Customer Service number on the back of your ID Card.

Please note: If you purchased your Empire policy through the ACA Marketplace, you will need to call the ACA Marketplace to cancel your policy and to retain coverage for your dependents. Please skip the cancellation section under the Authorizations and Agreements segment of this Application that requests your Empire Identification Number. ACA guidelines do not allow us to cancel policies obtained through the ACA Marketplace.

Empire BlueCross BlueShield
An Anthem Company

Application for Medicare Supplement – New York

Empire HealthChoice Assurance, Inc.
P.O. Box 659816 • San Antonio, TX 78265-9116

Instructions

For assistance, call us at **1-888-849-2420**. To be considered for coverage, you must live in **New York**. Please answer all questions fully. Submit application within 90-days of signature date.

Important Statements

Please read the six statements below.

1. **You do not need more than one Medicare Supplement policy or certificate.**
2. If you purchase this policy (certificate), you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy (certificate).
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid, for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Empire BlueCross BlueShield
An Anthem Company

Application for Medicare Supplement – New York

Empire HealthChoice Assurance, Inc.
P.O. Box 659816 • San Antonio, TX 78265-9116

☐ New Enrollment
☐ Change to Existing Empire Medicare Supplement Plan

Section A: Applicant Information (Please print and use black ink only.)

Last Name	First Name	MI	Sex ☐ M ☐ F
Home Street Address (Physical Address, not a P.O. Box)			Apt #
City	County	State	Zip Code
Mailing Address (if different than above)	City	State	Zip Code
Billing Address (if different than above)	City	State	Zip Code
Date of Birth (MM/DD/YYYY) / /	Age	Home Phone Number ( )	

Language Preference (Optional): ☐ Decline
Written Preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____
Spoken Preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Please complete the information below using your Medicare card (include all letters and numbers).

Medicare Claim Number: _____

Hospital (Part A) Effective Date: _____ (MM) / 01 (DD) / _____ (YYYY)

Medical (Part B) Effective Date: _____ (MM) / 01 (DD) / _____ (YYYY)

Section B: Plan Selection

I would like to apply for Medicare Supplement Plan (check only one box):

☐ Plan A ☐ Plan B ☐ Plan F ☐ Plan G ☐ Plan N

Policy Effective Date: _____ (MM) / _____ (DD) / _____ (YYYY)

Coverage is effective as of the 1st of the month following approval of your completed application. To ensure continuation of coverage, you can request an initial effective date other than the 1st of the month. The effective date must be within 90-days of application signature. After the initial effective date, your policy will move to a 1st of the month anniversary date.

Have you purchased a stand-alone Prescription Drug Plan (PDP)? ..... ☐ **Yes** ☐ **No**

a. If yes, with what company? _____ PDP Effective Date: ____ / ____ / _____

(continued)

PLEASE MAKE A COPY FOR YOUR RECORDS.

Section C: How Do You Wish to Pay Your Premium? (SEND NO MONEY NOW!)

Automated Bank Draft*

- ☐ Monthly – save $2 per month
- ☐ Quarterly
- ☐ Annual – save $48 per year

Paper Bill (Send to **Billing Address** in Section A)

- ☐ Quarterly
- ☐ Annual – save $48 per year

* Please complete the **Premium Payment Form**. Drafts are made to your account on the 5th day of the month.

Section D: Other Coverage Information

RESPONSES TO THE FOLLOWING QUESTIONS ARE REQUIRED FOR YOUR PROTECTION. To the best of your knowledge and belief, please answer all questions by marking "Yes" or "No" with an "X". If you recently lost, are losing or replacing other health insurance coverage and received a notice stating you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. **Please include a copy of the notice with your Application.**

1. a. Did you turn age 65 in the last 6 months? ☐ **Yes** ☐ **No**

b. Did you enroll in Medicare Part B in the last 6 months? ☐ **Yes** ☐ **No**

If yes, what is the effective date? _____

2. Are you covered for medical assistance through the state Medicaid program? ☐ **Yes** ☐ **No**

Note to Applicant: If you are participating in a "Spend-Down Program" and have not met your Share of Cost, please answer "No" to this question.

If yes,

a. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ **Yes** ☐ **No**

b. Do you receive any benefits from Medicaid **OTHER THAN** payments toward your Medicare Part B premium? ☐ **Yes** ☐ **No**

3. a. If you had coverage from any Medicare Advantage plan other than Original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates below. If you are still covered under the Medicare Advantage plan, leave "END" blank. (If you know your upcoming coverage end date, then enter that date).

START _____ / _____ / _____ END _____ / _____ / _____

b. If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ **Yes** ☐ **No**

c. Was this your first time in this type of Medicare Advantage plan? ☐ **Yes** ☐ **No**

d. Did you drop a Medicare Supplement policy to enroll in the Medicare Advantage plan? ☐ **Yes** ☐ **No**

4. a. Do you have another Medicare supplement or Medicare Select policy or certificate in force? ☐ **Yes** ☐ **No**

b. If so, with what company, and what plan do you have?

Company: _____ Plan: _____

If so, do you intend to replace your current Medicare Supplement or Medicare Select policy or certificate with this policy or certificate? ☐ **Yes** ☐ **No**

(continued)

Section D: Other Coverage Information *(continued)*

5. Have you had coverage under any other health insurance policy or certificate within the past 63 days? (for example, an employer, union or individual plan) ☐ **Yes** ☐ **No**

a. If yes, Company: _____ Policy Type: _____

b. If yes, what are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank. If you know your coverage end date, then enter that date.)

START _____ / _____ / _____ END _____ / _____ / _____

Policy Number: _____ Customer Service Phone Number: _____

Section E: Authorizations and Agreements

I, the applicant or my authorized representative:

1. affirm all answers provided on this application are true, complete and correct **(including information relating to Medicare coverage) and that any false statement or misrepresentation on the Application may result in loss of coverage under the policy** and that it is my/our responsibility for accurately completing this Application;

2. understand if coverage is rescinded for fraud or intentionally misleading statements Empire BlueCross BlueShield will reimburse any premium paid less any claims paid and I/we will be responsible for claims paid exceeding any premium paid;

3. understand that I/we are responsible for notifying Empire BlueCross BlueShield in writing of any new/changes to information on this application before coverage becomes effective that makes my application incorrect or incomplete;

4. understand that there is a six-month benefit waiting period for any condition that I received medical treatment or advice in the six months prior to the effective date of this Medicare Supplement policy. Prior health insurance coverage will be counted toward this 6-month benefit waiting period, if there is not a break in health insurance coverage greater than 63 days;

5. understand the selling agent (if applicable) has no authority to promise coverage or to modify the Company's underwriting policy, premium or terms of any Company coverage and that he/she may be compensated based on my enrollment;

6. understand upon acceptance that my Application will become part of the agreement between the Company and myself;

7. authorize Empire BlueCross BlueShield to use and disclose my personal information when necessary for the operation of my health or other related activities and that Empire BlueCross BlueShield will comply with the HIPAA Privacy Rules and any disclosures will be done in accordance with applicable laws;

8. understand that my payment by check (or resubmission due to insufficient funds) may be converted to an electronic Automated Clearinghouse (ACH) debit transaction, that my check will not be returned to me and that this process will not enroll me in any automatic debit process;

(continued)

PLEASE MAKE A COPY FOR YOUR RECORDS.

Section E: Authorizations and Agreements *(continued)*

9. acknowledge responsibility for any overdraft fees permitted by state law;

10. acknowledge receipt of:

- Choosing a Medigap Policy: *A Guide to Health Insurance for People with Medicare,*
- the *Outline of Coverage,* and
- a copy of this Application.

Section F: Policy Issuance

IMPORTANT: This Application cannot be processed until the applicant signs below. By signing below, the applicant certifies that he/she understands and agrees to the Authorizations and Agreements outlined in the Application.

Please do not cancel your present coverage, if any, until you receive documentation from Empire BlueCross BlueShield, such as an ID card or written notification, showing that your Application has been approved.

To ensure timely processing, verify the following:

1. Complete, sign and date all sections as indicated by signature boxes.
2. If you want the convenience of automatic bank draft for payment purposes, be sure to complete the **Premium Payment Form.**
3. If replacing a Medicare Supplement or Medicare Advantage policy, the **Replacement Notice** is signed and dated by both you and your insurance agent (if applicable) and returned with your Application.

Please mail the entire Application (including any additional forms) to the address below:

Empire BlueCross BlueShield
P.O. Box 659816
San Antonio, TX 78265-9116

OR, fax to: 1-844-236-7967

Signature of Applicant, or Authorized Representative (if applicable)* **PLEASE MAKE A COPY FOR YOUR RECORDS.** **X**	Date

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

*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to Application (such as a Power of Attorney).

— SEND NO MONEY NOW —
PAYMENT IS NOT DUE UNTIL YOUR APPLICATION IS APPROVED.

Section G: Agent/Broker Information Only: If Application is being made through an agent/broker, he or she must complete the following, and the Notice of Replacement included with the Application, if appropriate. *(Attach additional sheets if necessary.)*

IMPORTANT: Before this form can be processed, the agent/broker's current health and life license must be on file. In addition, the agent/broker must be appointed with us.

Agent/Broker No.:

_____

Agency No.:

_____

(Any commission will be processed using these identification numbers.)

Agent/Broker's Printed Name:

_____

Phone No.: (_____) _____

Fax No.: (_____) _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____

Attestation – Please check one of the following:

☐ I did not assist this applicant in completing and/or submitting this Application by phone, e-mail or in person.

☐ I certify that the applicant has read, or I have read to the applicant, the completed Application. To the best of my knowledge, the information on this Application is complete and accurate. I explained to the applicant, in easy-to understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation. I certify that the applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the policy.

Agent: If you state any material fact that you know to be false, you are subject to a civil penalty.

List all health insurance policies sold to the applicant that are still in force:

Company Name	Policy/ Certificate Number	Type of Coverage	Policy Effective Date	Policy Term Date (if applicable)

List all health insurance policies sold to the applicant in the past five (5) years that are no longer in force:

Company Name	Policy/ Certificate Number	Type of Coverage	Policy Effective Date	Policy Term Date (if applicable)

(continued)

PLEASE MAKE A COPY FOR YOUR RECORDS.

Section G: Agent/Broker Information Only: *(continued)* If Application is being made through an agent/broker, he or she must complete the following, and the Notice of Replacement included with the Application, if appropriate. *(Attach additional sheets if necessary.)*

I have read and understand the Application. I certify that the applicant has both Medicare Parts A and B, I have given the applicant the *Guide to Health Insurance for People with Medicare*, the *Outline of Coverage* for the policy applied for and a copy of this application. I have requested and received documentation that indicates that the policy applied for will not duplicate any health insurance coverage. I have verified the information in the Replacement Notice section. I have reviewed the current health insurance coverage of the applicant and find that additional coverage of the type and amount applied for is appropriate for the applicant's needs.

Agent/Broker's Signature: X _____ **Date of Signature:** _____

Notice to Applicant Regarding Replacement of
Accident and Health Insurance, HMO Coverage or Employer-provided Health Benefit Arrangement

Empire HealthChoice Assurance, Inc.
P.O. Box 659816 • San Antonio, TX 78265-9116

Save This Notice! It May Be Important to You in the Future.

According to information you have furnished, you intend to terminate your existing existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a policy to be issued by Empire HealthChoice Assurance, Inc. Your new policy will provide thirty (30) days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this policy (certificate). Terminate your present coverage only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction (does) (does not) duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) checked below:

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

  _____

- ☐ Other. (please specify) _____

1. Health conditions which you may presently have may be considered preexisting conditions and may not be immediately or fully covered under the new policy (certificate). This could result in denial or delay of a claim for benefits under the new policy (certificate), whereas a similar claim might have been payable under your present coverage. (This paragraph may be deleted if the replacement does not involve application of a new preexisting condition limitation.)
2. State regulation provides that in applying a preexisting condition limitation, a Medicare supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare supplement insurance, Medicare select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy or certificate. (This paragraph may be deleted if the replacement does not involve application of a new preexisting condition limitation.)
3. If you still wish to terminate your present policy or certificate and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.

X _____
(Signature of Agent, Broker or Other Representative)*
Typed Name and Address of Issuer, Agent or Broker

X _____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales

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X _____
(Signature of Agent, Broker or Other Representative)*
Typed Name and Address of Issuer, Agent or Broker

X _____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales

Empire HealthChoice Assurance, Inc.
P.O. Box 659816
San Antonio, TX 78265-9116
Fax: 1-844-236-7967

Empire BlueCross BlueShield
An Anthem Company

Medicare Supplement - Premium Payment Form

With Automatic Bank Draft, Empire BlueCross BlueShield
will automatically draft your premium directly from your checking account.

Simplify your life! It saves you valuable time and money.

Pay annually and save $48 or sign up for monthly Automatic Bank Draft and save $2 per month. ... It is easy to sign up!

(Available on policies with an effective date on or after June 1, 2010.)

Full Name (please print):		**Phone**	
Home Street Address (Physical Address, not a P.O. Box)			**Apt. #**
City	**County**	**State**	**ZIP Code**
Mailing Address (if different than above)	**City**	**State**	**ZIP Code**
Billing Address (if different than above)	**City**	**State**	**ZIP Code**

■ EXISTING MEMBER (Changing Payment Option to Automatic Bank Draft)

Empire BlueCross BlueShield Identification Number (as shown on ID card): _____

(Allow 6-8 weeks to process your authorization. Continue to pay as billed until receiving a confirmation letter that we have set up Automatic Bank Draft for your premiums.) For existing members, return this form to: Empire HealthChoice Assurance, Inc. P.O. Box 659816, San Antonio, TX 78265-9116

■ NEW APPLICANT (Initial Submission of a Medicare Supplement Application)

I understand that the premium for the coverage I have selected is $_____.*

* *If your application is accepted and the amount you indicated is less or more than the actual premium amount, the difference will be reflected as a debit or credit on the first bill you receive. If the amount received is not within our payment guideline threshold, we will notify you.* ***To ensure proper payment setup, this form MUST be returned with your Application.***

Premiums are subject to change on or after the policy renewal date in accordance with the terms of the Policy. Your Premium Billing Preference selection does not guarantee your Premium for any specific time period. The policy renewal date is defined as generally January 1, subject to state approval. Please refer to your *Outline of Coverage* for additional information regarding changes in Premiums.

BANK INFORMATION (For Existing Member)

Deduct Premium: ☐ Monthly* ☐ Quarterly ☐ Annually*
(* Applicable discounts for monthly or annual Automatic Bank Draft are not guaranteed and are subject to change.)

Deduct Monthly Premium From: ☐ Checking Account **Start Date:** _____/____/_____

Is this a business account: ☐ Yes ☐ No

Account Holder Name(s):

Name of Financial Institution:

Bank Routing/Transit Number (9 digits)	Bank Account Number
_____ _____ _____ _____ _____ _____ _____ _____ _____	_____

I hereby authorize the Company to make withdrawals from the account indicated above for the then-current premium, and the designated financial institution named above to debit the same account.

I understand that I am responsible to pay my premiums on schedule until set up on Automatic Bank Draft. If any premiums are owed to Empire BlueCross BlueShield when set up, I authorize my bank to draft both the past due premium along with current premium to ensure my coverage stays in effect. If I close this account, it is my responsibility to provide notification at least two weeks in advance of closing the account. I acknowledge responsibility for any overdraft fees permitted by state law.

I understand that this authorization is in effect until I either submit written notification or by phone, allowing reasonable time to act upon my notification. (**Exception:** In the event payment is returned due to insufficient funds, you will be converted to paper billing.) I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account. I understand Empire BlueCross BlueShield and my financial institution have the right to discontinue the bank draft if they wish to do so. I understand my monthly bank statement will reflect the premium transaction and that I will not receive a bill.

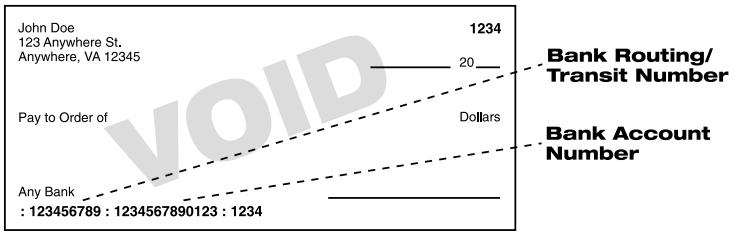
Empire will accept premium payments made on behalf of an applicant or member from **ONLY** the following:

- Family member related by blood, marriage or adoption;
- Legal Guardian and/or Conservator;
- Powers of Attorney; or
- a Trustee acting on behalf of the member that is a Beneficiary of the Trust.

Return this authorization as indicated above. **No service fees apply when paying by Automatic Bank Draft.**

Account Holder's Signature (as it appears on your bank account)	**Date**

Refer to the image below to identify where to locate the Routing Number and Bank Account Number. Do not include the check number as part of the Routing or Account Number



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

Empire BlueCross BlueShield

An Anthem Company

AUTHORIZATION FOR THIRD PARTY DESIGNATION TO RECEIVE NONPAYMENT OF PREMIUM NOTICES

Under New York law, you may choose someone (called a third party designee) to get notices if we do not receive your Medicare Supplement insurance premium. In the event your premium is not received by its due date, a THIRD PARTY BILLING STATEMENT will be sent to this designated person. If your coverage is terminated for non-payment, we will also send a THIRD PARTY TERMINATION letter to this designee. This is optional and can be done at the time of Application or at a later date. Both you and the person you choose must sign this form.

Please note that for designation purposes, Empire will accept premium payments made on behalf of an applicant or member from **ONLY** the following:

- Family member related by blood, marriage or adoption;
- Legal Guardian and/or Conservator;
- Powers of Attorney; or
- a Trustee acting on behalf of the member that is a Beneficiary of the Trust.

THIRD PARTY DESIGNEE INFORMATION:

Last Name **First Name** **Middle Initial**

Mailing Address **Apartment Number**

City **State** **Zip Code**

Telephone Number

I understand that, as third party designee, I must notify both the member and Empire HealthChoice Assurance, Inc. in writing if I decide to terminate the Designation and affirm that I meet the above guidelines as to whom may serve as a Designated Third Party.

_____ _____

Designated Third Party Signature Date

(Continued on back)

Applicant, Member Information:

Member Name: _____

Empire Medicare Supplement Member Identification Number: _____ (required)

Date of Birth:_____

I authorize Empire HealthChoice Assurance, Inc. to send, to the Third Party Designee, a THIRD PARTY BILLING STATEMENT and a THIRD PARTY TERMINATION letter for the member named above.

This Authorization is valid for the duration of my coverage with Empire unless a different expiration date is indicated here: _____ (specify month, day, year).

I understand that this Designation does not include the ability to make decisions concerning my health care. I also understand that I may revoke this designation at any time, except to the extent that action has been taken in reliance upon it, by submitting a request in writing to Empire. I understand that the person/entity I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect the information.

I do hereby affirm that I am the member or the person with the legal authority (appropriate legal documentation must be provided) to act on behalf of the applicant, member and affirm my Designated Third Party meets the above guidelines as to whom may serve as a designee.

_____ _____

Applicant, Member/Legally Authorized Person Signature Date

_____

Authority of person signing form (e.g., Power of Attorney)

Mail to:

Empire HealthChoice Assurance, Inc.
P.O. Box 659816
San Antonio, TX 78265-9116

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