HIP HMO Prime
Low Option

Low Option	
SINGLE	**$ 1,140.00**
E+1	**$ 1,975.00**
FAMILY	**$ 2,975.00**

(Renewal 1/31/22)
Available in NY, NJ*, CT*

**In NJ uses QUALCARE network, in CT uses CONNECTICARE network*

Low Option

$ 30.00 – OFFICE CO-PAY Primary
$ 60.00 – OFFICE CO-PAY Specialist
$ 1,500.00 – HOSPITAL CO-PAY
$15 Generic only

See Summary enclosed for more benefits

Network Providers can be found at: www.emblemhealth.com

If E+1 or Family, Marriage cert & Dependents Birth cert required (Copy)

HIP HMO Prime Low Option

Enrollment Worksheet

(Effective through 1/31/22)

Low Option Rates

Single	**$ 1,140.00**
E+1	**$ 1,975.00**
Family	**$ 2,975.00**

Medical Premium:	$_____
One Time Processing Fee:	$ **125.00**
Total Contribution at Enrollment:	$_____

- **Make One Check Payable to Nu Era Benefits**
- **Monthly billing is done via Paper Invoice or Electronic (EFT) Billing.**
- **$20 Billing fee for Paper Invoice, No Charge For EFT Billing.**
- **Applicant *must* complete Billing form.**
- **Applicant *must* complete Emblem & Association Enrollment Forms.**
- **Applications *must* be received by 20th of the month prior to the start date**
- **Mail Applications to: Nu Era Benefits 20 Madison Avenue, Valhalla NY 10595**

Member Name _____ Rep. Name _____

Member Signature _____ Rep. Signature _____

Date _____ Rep. Phone Number _(_____)_____

Please note that it will take 2- 3 weeks after your effective date for your ID cards to arrive from the carrier

Initial _____

EmblemHealth®

NETWORK NEWS

EmblemHealth's Prime Network is Now Accessible to Members Throughout the Tristate Region

As part of our ongoing efforts to provide quality, affordable, and coordinated health care, EmblemHealth has made it even easier and more convenient for our members who are employed by a New York company and reside in either New Jersey or Connecticut to have access to the providers they want and need when using our Prime Network.

As of July 1, 2016, EmblemHealth expanded our Prime network to include QualCare Network in New Jersey; beginning January 1, 2017, the expansion continues to include ConnectiCare (CCI) in Connecticut.

Below is a snapshot of the number of additional providers and facilities members can access as part of our tristate network expansion:

NEW JERSEY: QUALCARE HMO NETWORK*	CONNECTICUT: CONNECTICARE*
• HMO providers – 41,773	• HMO providers – 17,084
• PPO providers – 43,782	• Ancillary Providers – 1,551
• Ancillary Providers – 3,887	• Facilities – 380
• Facilities – 3,703	• Urgent Care Centers – 84
• Urgent Care Centers – 69	

*Network is subject to change

NEW TRISTATE MEMBER ID CARDS

- The new member ID cards will display all three company logos (EmblemHealth, ConnectiCare and QualCare).
- A letter accompanying new ID cards will announce the network expansion into Connecticut via partnership with CCI. All other members tied to the Prime Network will receive their new member ID card through our usual channels, such as PCP change, ID card request or plan renewal.

For a complete list of network providers, members can refer to our online provider directory at **emblemhealth.com/Find-a-Doctor**.

If you have questions, please contact us at the EmblemHealth Customer Service telephone number listed on the back of the member ID card, 8 am to 6 pm, Monday to Friday (except major holidays) TTY/TDD: **711**

EMB_BR_FLY_30498_Tristate_Expansion 10/16

EmblemHealth®

SUMMARY OF BENEFITS

HIP Prime Network

LOW option

➢ MAJOR COPAYMENT PROVISIONS	HIP PRIME™
PCP Office visits	$30 copay per visit
Specialist Office visits	$60 copay per visit
Hospital admission	$1500 copay per Hospital Admission
Emergency room copay (waived if admitted)	$100 copay per visit
Prescription drugs	$15 generic only (Subject to Drug Formulary) Contraceptives Included (Formulary copays are reduced by 50% when utilizing the HIP Mail Order Pharmacy Service. Up to a 90 day supply may be obtained.)

➢ INPATIENT HOSPITAL SERVICES	HIP PRIME™
• Hospital and Physician Services	Subject to Hospital admission copay
• Semi-private Room and Board	Included in Hospital Admission copay
• Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, X-rays and lab tests	Included in Hospital Admission copay
• Short-term speech, physical, occupational and respiratory therapy (when part of an acute admission)	Included in Hospital Admission copay Short-term only
• Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission)	Not Covered
• Radiation therapy and chemotherapy	Included in Hospital Admission copay
• Pre-admission testing	Included in Hospital Admission copay
• Human organ transplants	Included in Hospital Admission copay

➢ OUTPATIENT MEDICAL CARE	HIP PRIME™
• PCP office visits	Subject to PCP office visit copay
• Specialist office visits	Subject to Specialist office visit copay
• Preventive care, including physical exams, ear exams, health education and counseling, pap smear, mammography and immunizations	$0 Copay
• Well-child care	No copay
• Diagnostic services including X-ray, lab tests, EKG's	Included in PCP office visit copay
• Prenatal, postnatal care in physician's office	No copay
• Ambulatory surgery	$75 copay per visit
• Second medical and surgical opinion	No copay
• Routine foot care	Not covered
• Chiropractic services	Subject to Specialist office visit copay

(continued on next page)

EmblemHealth®

SUMMARY OF BENEFITS

HIP Prime Network

➢ MENTAL HEALTH AND SUBSTANCE USE DISORDER	HIP PRIME™
Mental Health Care	
• **Inpatient**	
- Treatment of Mental Illness	Subject to Hospital admission copay; Unlimited days per calendar year
• **Outpatient**	
- Treatment of Mental Illness	$30 copay Unlimited Visits per calendar year
Substance Use Disorder • Inpatient Detoxification	Subject to Hospital admission copay no limit on days per calendar year
• Inpatient Rehabilitation Treatment	Subject to Hospital admission copay unlimited days per calendar year
• Outpatient Rehabilitation Treatment	$25 Copay per visit, Unlimited Visit - per calendar year

➢ SPECIAL KINDS OF CARE	HIP PRIME™
Emergency and urgent Care	
• In hospital emergency room	Subject to Emergency room copay
• In urgent care facility	Subject to PCP office visit copay
• In physician's office	Subject to PCP office visit copay
• Ambulance service to the hospital	No copay
Home Health Care	No copay; 40 visits per calendar year
Hospice Care	No copay; 210 days
Skilled Nursing Facility care	$0 copay; 30 days per calendar year
Dialysis treatment	$25 copay per visit
Diabetes equipment, supplies and education	$25 copay per month
Outpatient physical, speech, occupational and respiratory therapy.	Subject to Specialist office visit copay; 30 visits per calendar year
Family Planning Services	Covered
Infertility Diagnosis and Treatment	Subject to applicable copays
In-vitro Fertilization	Not Covered
Dental Care • General dental care	Covered at reduced member fee schedule
• Preventive dental care - Oral exam (One every six months) - Cleaning (One every six months) - Topical application of fluoride for children age 16 and under (One every six months) - Fluoride applications age 17 and over (One every six months)	$5 copay per visit $10 copay per visit $5 copay per visit Copay to be determined by zip code
Durable Medical Equipment	$0 annual deductible
Private Duty Nursing	Covered in full

(continued on next page)

EmblemHealth®

SUMMARY OF BENEFITS

HIP Prime Network

Hearing aids	Not covered; Cochlear implants covered
Optical care	
• Refractive Eye Exams	$15 copay
• Eyeglasses	$45 for a complete pair every 24 months

➢ ADDITIONAL BENEFITS	HIP PRIME™
• Nurse Advice Line	Not Covered
• Wellness Rider	Not Covered

FOOTNOTES

** Drugs are dispensed in accordance with HIP's Drug Formulary. Please refer to your Prescription Drug Rider for details.*

Except for emergency care, the above benefits and services are covered only when provided or referred by a HIP Primary Care Physician and/or approved in advance by the HIP Care Management Program. HIP Participating Physicians and Providers have contracted with HIP to provide care to our members; they are not employees, agents, servants or representatives of HIP. This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Contract or Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.
HIP Health Plan of New York (HIP) is an EmblemHealth company.

EmblemHealth

Low

TRANSACTION FORM FOR GROUP ACCOUNTS

I. SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	Sex	Social Security Number

Street Address	Apt.	City	State	ZIP Code

Were you ever a member of EmblemHealth?
☐ NO ☐ YES
If YES, member ID _____

Marital Status:
☐ Single ☐ Married
☐ Domestic Partner

Birth Date:
Mo. Day Yr.

Home Tel. #: _____
Work Tel. #: _____
Cell Tel. # (see back of form*): _____

Email Address: _____
☐ **"GO PAPERLESS" and save trees (see back of form)†**

Applicant's hours worked per week:
☐ at least 30 hours ☐ less than 30 hours ☐ COBRA

Type of Coverage: ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child

Note: If electing Young Adult Coverage, please submit a completed Young Adult Election Form.

Primary Care Physician Name: (Not required for EPO/PPO members) _____ ID Number: _____

OB/GYN Selection Name: (Optional) _____ ID Number: _____

Are you covered by any other health insurance or Medicare?
☐ NO ☐ YES If YES, indicate:
Insurance Co. Name: _____
Insurance Co. Telephone #: _____ Type of Coverage: _____
Policy #: _____ Effective Date: _____

Check One:
☐ New Enrollment
☐ Reinstatement
☐ Termination
☐ Change to Ind.

Status:
☐ Add Dependent
☐ Remove Dep.
☐ Address Change
☐ Name Change

Transfer:
☐ To Another Carrier
☐ EmblemHealth Group Change:
From: _____
To: _____

II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY

Note: A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

Last Name (if different)	First Name	Social Security Number	Sex	Relationship	Birth Date Mo.	Day	Yr.	✓ if Disabled[1]	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
DEPENDENT				☐ Spouse ☐ DP ☐ Child						
Current Health Insurance Information:	Carrier Name: _____			Coverage Begin Date: _____		Coverage End Date: _____				
DEPENDENT				☐ Child						
Current Health Insurance Information:	Carrier Name: _____			Coverage Begin Date: _____		Coverage End Date: _____				
DEPENDENT				☐ Child						
Current Health Insurance Information:	Carrier Name: _____			Coverage Begin Date: _____		Coverage End Date: _____				

[1]For dependent adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Dependent" box, and follow the instruction for required documentation.

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form.
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 material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant must sign here: _____ **Date:** _____

III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group: Local 450A	Group Number: 1123271-002	☐ EmblemHealth ☐ GHI ☐ GHI HMO ☐ HIP Plan Name: _____	If you selected a small group metal plan, please check which type: ☐ Platinum ☐ Gold ☐ Silver ☐ Bronze

Requested Effective Date: Medical: _____ Dental: _____	Hire Date:	Waiting Period:	Date Submitted:	Approved By: (Group Plan Administrator)

Instructions to Benefit Administrators or Group Representatives: For groups with 100 or fewer full-time equivalent eligible employees, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

Amalgamated Union
Local 450A

258 Saw Mill River Road
Elmsford, NY 10523
Tel: (914) 592-1515

Membership Fee $ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

PLEASE PRINT **MEMBERSHIP APPLICATION** PLEASE PRINT

Name _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Date of Birth _____ Married _____ Single _____ Home Phone _____

Employed By _____ Date Employment Started _____

Effective Date _____ Occupation _____ Hourly Rate _____

I hereby apply for and agree to membership in Local No. 450A and of my own free will designate Local 450A as my sole and exclusive collective bargaining agent to negotiate and conclude all agreements on my behalf relating to hours, wages, benefits, unit and working conditions; and I do authorize Local No. 450A to act for and represent me in all matters arising out of and in connection with my employment. I agree to abide by and be subject to the Constitution and By-Laws and rules and regulations of Amalgamated Union Local 450A as the same now exists or may be amended. I authorize dues or fees to be deducted from my wages and paid over to the Local in accordance with the check-off terms stated below. My union dues will be used to protect my rights and strengthen the union by paying for various expenses including union representation, collective bargaining, meeting expenses, organizing new workers and for fees to various labor counsels.

X Signature ..... Date .....

DEDUCTION AUTHORIZATION

You are hereby authorized and directed to deduct an initiation fee as required by Local 450A in addition thereto, to deduct each month, my monthly membership dues or agency fees from my wages, and to remit all such deductions so made to Local 450A no later than seven days following the date of deduction. This authorization is a voluntary act on my part and shall be irrevocable for a period of one year until termination date of the Collective Bargaining Agreement, whichever is sooner, and shall, however, renew itself from year to year unless I give written notice to Local No. 450A and to my employer revoking this authorization.

X Signature ..... Date .....

DEFFERED INITIATION PAYMENT

I the undersigned, understand that the Union Initiation Fee is due and owing Local No. 450A at the end of my (30) day trial period with the employer. In the event my employment is terminated prior to the full payment of my initiation fee, then, and in the event, I agree and authorize my employer to deduct the balance due to the Union, from my final paycheck.

X Signature ..... Date .....

PLEASE PRINT **AMALGAMATED UNION LOCAL 450 A WELFARE FUND APPLICATION** PLEASE PRINT

Name _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Date of Birth _____ ☐ Married ☐ Single ☐ Male ☐ Female Home Phone _____

Employed By _____

Beneficiary's Name _____ Relationship _____

Beneficiary's Address _____ City _____ State _____ Zip _____

List all eligible dependents (below) including spouse

FIRST NAME	(last name if different)	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NO.

I UNDERSTAND THAT ANY FALSE STATEMENT, OR WILLFUL CONCEALMENT, COVER-UP OR FAILURE TO DISCLOSE ANY FACT WHICH IS REQUIRED TO BE DISCLOSED ON THIS FORM MAY RESULT IN LOSS OF ELIGIBLE COVERAGE. I HEREBY CERTIFY THAT ALL INFORMATION CONTAINED ABOVE TRUE AND COMPLETE.

X Signature ..... **Date** .....

AMERICANS FOR FINANCIAL INDEPENDENCE
MEMBERSHIP FORM

MEMBER INFORMATION

MEMBER LAST NAME	MEMBER FIRST NAME
MEMBER SS#	MEMBER DOB
HOME PHONE	CELL PHONE
MEMBER GENDER ☐ MALE ☐ FEMALE	EMAIL
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER	
STREET ADDRESS	APT #
CITY	STATE / ZIP
EMPLOYED 20+ HRS PER WEEK (ON AVERAGE) ☐ NO ☐ YES ☐ W2 ☐ K1 ☐ SCHEDULE C	OCCUPATION
BUSINESS NAME	BUSINESS PHONE
BUSINESS ADDRESS	BUSINESS EMAIL

SPOUSE / DOMESTIC PARTNER INFORMATION (*IF APPLICABLE*)

SPOUSE / PARTNER LAST NAME (IF DIFFERENT)	SPOUSE / PARTNER FIRST NAME
SPOUSE / PARTNER SS#	SPOUSE / PARTNER DOB
SPOUSE / PARTNER GENDER ☐ MALE ☐ FEMALE	SPOUSE / PARTNER EMAIL

DEPENDENT INFORMATION (*IF APPLICABLE*)

LAST NAME (IF DIFFERENT)	FIRST	MIDDLE	DOB	AGE	RELATIONSHIP TO MEMBER	SS #

PLAN SELECTION

PLAN NAME	EFFECTIVE	PREVIOUS CARRIER

**** All documents included in my application for benefits have been completed accurately and truthfully to the best of my knowledge.*

MEMBER SIGNATURE **DATE**

Acknowledgement of ID Numbers & Card Arrival

I acknowledge that ID cards can take up to 10-15 Business days after the effective date to arrive from the Carrier.

In addition I acknowledge that ID Numbers can also take up to 10-15 business days to be sent to me from the association if I do so request my ID number.

Signature of member Date

_____ ____/____/_____

Acknowledgement of Late Enrollment

I acknowledge that my enrollment materials were submitted after the 20th of the month prior to the effective date of coverage.

Therefore as a result of the delay, I understand and accept that I may not be able to verify my eligibility sooner than 30 days from the start date of enrollment.

I further understand and accept that my identification card(s) may arrive no sooner than 30 days from the requested start date of enrollment.

I also understand and accept that I may have to contact the carrier directly regarding any out-of-pocket expenses and/or claims issues.

I understand that if I need additional assistance in expediting the process mentioned above I can contact customer service (914)-366-6868.

Signature of member Date

_____ ____/____/_____

Billing Application

Requested effective date (mm/dd/year) ____/____/____

Billing Information – Invoices should be sent to:

_____

Contact Person **Title**

_____

Company Name

_____

Address

_____

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

_____

Telephone **Fax**

Broker: _____

Payment Options;

☐ EFT-Direct Withdrawal (No Charge, please complete authorization form below)

☐ Monthly Invoice ($20 Billing Fee)

EFT AUTHORIZATION

Please Note there is a $30 Insufficient Funds Fee

Bank Route Code#_____ Bank Account#_____

Please deduct payment of $_____ between the 21st & 26th of the month Prior to the next months coverage.

I understand this authority is to remain in full force and effect until the company has received written notification from me of its termination in such time and such manner as to afford the company and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by sending written notification by fax to (914) 428-8080 three (3) business days or more before this payment is scheduled to be made. **Please be aware that your bank statement will reflect the debit as Nu Era Benefits.**

Signature of Depositor: _____

Date: ____/____/_____

PLEASE ATTACH A CHECK MARKED

VOID

TO ENSURE ACCURACY