



EmblemHealth Exclusive Provider Organization (“EPO”) Value Application for Large Group (100+ Full-time equivalent Employees over the prior calendar year)

For use with EmblemHealth insurance programs that are underwritten by Health Insurance Plan of New York (HIPIC)

PRINT IN INK

SECTION I: GROUP INFORMATION			
Company Name			Date
If applicable, DBA Company Name			
Address			
City	State	ZIP	County
Telephone No. ()		Fax No. ()	
Company Officer’s Name		Email Address	
Title			
Group Contact		Title	
Telephone No. ()		Email Address	
Address <input type="checkbox"/> Same as above			
Address			
City	State	ZIP	County
Additional Office Locations			
Nature of Business		SIC/NAIC Code	Taxpayer ID No.

SECTION II: BILLING			
Premium invoices should be sent to:			
Address			
City	State	ZIP	County
Telephone No. ()		Email Address	
Contact Person (if different than above)			
Telephone No. ()		Email Address	

SECTION III: GROUP ADMINISTRATION

A. Number of Total Employees (no matter how many hours per week they work) _____

B. Average Total Employees over the past 12 months _____

C. Number of Full-Time Eligible Employees: _____

D. Number of Employees Applying _____

E. Number of COBRA Participants _____

* Use the “full time equivalent” (FTE) employee counting method set forth in 26 U.S.C. 4980(H) to determine group size. This is the same calculation method used to determine employer liability under the “Shared Responsibility for Employers” provisions of the Affordable Care Act (ACA) and Internal Revenue Code. Note that employees of affiliated entities under common control (such as parent corporations and wholly owned subsidiary corporations) must be counted together for this purpose.

Employee Eligibility:

Active Employees: All active, permanent, full-time employees who work at least _____ hours per week (minimum 20 hours/week).

Are any classes excluded? Yes No

If yes, indicate classes excluded: _____

Retired Employees: Yes No

A retired employee is defined as an employee who is: (check any that apply)

Retired on pension by the employer

Name and Address of Insurer	Type of Coverage	Effective Date of Policy	Termination Date of Policy

SECTION IV: COPAYMENT/BENEFIT OPTIONS (Select one from each category)

Desired Effective Date: _____

Medical deductible	<input type="checkbox"/> \$0 <input type="checkbox"/> \$500/\$1,000 <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$3,500/\$7,000
Prescription drug deductible	<input type="checkbox"/> \$0 <input type="checkbox"/> \$100
Medical coinsurance	<input type="checkbox"/> 0% <input type="checkbox"/> 10% <input type="checkbox"/> 30%
Plan year out-of-pocket max	<input type="checkbox"/> \$7,150 / \$14,300
PCP office visit	<input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50 <input type="checkbox"/> \$60
Specialist office visit	<input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50 <input type="checkbox"/> \$65 <input type="checkbox"/> \$75
Inpatient hospital admission	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Subject to deductible and coinsurance
Ambulatory surgery center facility	<input type="checkbox"/> \$150 <input type="checkbox"/> \$250 <input type="checkbox"/> \$350 <input type="checkbox"/> \$400
Outpatient hospital surgery facility	<input type="checkbox"/> \$150 <input type="checkbox"/> \$250 <input type="checkbox"/> \$350 <input type="checkbox"/> \$400
Emergency room	<input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$250
Urgent care center	<input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100
Ambulance	<input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$250
Prescription Drug Options	<input type="checkbox"/> \$15 Preferred Generic/\$30 Preferred Brand Name/\$50 Non-Preferred <input type="checkbox"/> \$15 Preferred Generic/\$35 Preferred Brand Name/\$75 Non-Preferred, subject to deductible <input type="checkbox"/> \$20 Preferred Generic/\$40 Preferred Brand Name/\$100 Non-Preferred, subject to deductible
Outpatient mental health care	<input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50 <input type="checkbox"/> \$60
Outpatient substance use care	<input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50 <input type="checkbox"/> \$60
Outpatient habilitation services	<input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50 <input type="checkbox"/> \$65 <input type="checkbox"/> \$75
Outpatient rehabilitation services	<input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50 <input type="checkbox"/> \$65 <input type="checkbox"/> \$75
Diabetic supplies	<input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50 <input type="checkbox"/> \$60
Durable medical equipment	<input type="checkbox"/> Covered in full

SECTION IV: COPAYMENT/BENEFIT OPTIONS (Select one from each category) - continued

Dialysis treatment	In PCP Office <input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50 <input type="checkbox"/> \$60 Other Outpatient locations <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50 <input type="checkbox"/> \$65 <input type="checkbox"/> \$75
Home health care	<input type="checkbox"/> 40 visits/\$0
Refractive eye exam	<input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50 <input type="checkbox"/> \$65 <input type="checkbox"/> \$75
Optical	<input type="checkbox"/> Glasses only, 1 pair every 24 months. Frames \$0 copay for \$80 allowance, 20% discount on balance over \$80. Standard plastic lenses \$35. Standard progressive lenses \$100. Premium progressive lenses \$100, 20% discount on balance over \$120. <input type="checkbox"/> Glasses and Contacts, 1 pair every 12 months. Frames \$0 copay for \$80 allowance, 20% discount on balance over \$80. Standard plastic lenses \$0. Standard progressive lenses \$65. Premium progressive lenses \$65, 20% discount on balance over \$120. Conventional contact lenses \$0 for \$70 allowance, 15% discount on balance over \$70. Disposable contact lenses, \$0 for \$70 allowance, plus full balance over \$70. <input type="checkbox"/> Glasses and Contacts, 1 pair every 24 months. Frames \$0 copay for \$80 allowance, 20% discount on balance over \$80. Standard plastic lenses \$0. Standard progressive lenses \$65. Premium progressive lenses \$65, 20% discount on balance over \$120. Conventional contact lenses \$0 for \$70 allowance, 15% discount on balance over \$70. Disposable contact lenses, \$0 for \$70 allowance, plus full balance over \$70.
Preventive dental (Adult and Pediatric)	<input type="checkbox"/> Covered <input type="checkbox"/> Not covered
Inpatient mental health	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Subject to deductible and coinsurance
Inpatient substance use services	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Subject to deductible and coinsurance
Inpatient habilitation services	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Subject to deductible and coinsurance
Inpatient rehabilitation services	<input type="checkbox"/> \$1,000 <input type="checkbox"/> Subject to deductible and coinsurance
Skilled nursing facility	<input type="checkbox"/> \$0 <input type="checkbox"/> Subject to deductible and coinsurance
Dependent coverage (Must select one)	<input type="checkbox"/> 26 end of month <input type="checkbox"/> 29 end of month <input type="checkbox"/> 26 end of year <input type="checkbox"/> 29 end of year
Domestic partners	<input type="checkbox"/> No <input type="checkbox"/> Yes

MONTHLY RATES (to be completed by your broker or EmblemHealth representative)

	2 TIER	3 TIER	4 TIER
Individual	\$	\$	\$
Two Persons		\$	\$
Employee & Child(ren)			\$
Employee & Spouse Family	\$	\$	\$

SECTION V: ENROLLMENT POLICIES

CLASS: _____

EMPLOYER CONTRIBUTIONS

- Employee: _____ % or \$ _____
- Family: _____ % or \$ _____
- Other: _____

NEW HIRE ELIGIBILITY POLICY

- Date of Hire First of the month following date of hire

PLUS:

- 30 Days 60 Days 90 Days

- Other (please specify): _____

Note: The waiting period may not exceed 90 days.

TERMINATION POLICY

- Date Terminated End of Month Other _____

SECTION VI: GROUP SIZE

For employer groups comprised of one or more employees, please check your current employer status below to ensure proper coordination of benefits for your Medicare Eligible Active Employees (*you must check one of the boxes below*):

- A. Employed fewer than twenty (20) full time or part time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year).
- Employed twenty (20) or more full or part time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20)

NOTE: All employers that are treated as a single employer under Internal Revenue Code Section 52 must be treated as a single employer for purpose of the Medicare secondary payer rules. According to Internal Revenue Code Section 52, all employees of all corporations that are members of the same controlled group of corporations must be treated as employed by a single employer. This means that if a parent company owns at least fifty percent (50%) of a subsidiary, then the number of employees of the parent and the subsidiary must be combined for purposes of determining the 20-employee threshold. Similarly, brother-sister corporations may be combined in some cases if the parent

- B. Please check here if your group is a large group health plan. A large group health plan is a plan of, or contributed to by, an employer or employee organization to provide health benefits that cover the employees of at least one (1) employer that normally employed at least one hundred (100) full-time equivalent employees over the previous calendar year on a typical business day.

SECTION VII: BROKER INFORMATION

Primary Selling Agent Name:	Commission %
License Number:	SA Code:
Address:	
Telephone No.: ()	Fax No.: ()
Email Address:	

Secondary/Split Selling Agent Name:	Commission %
License Number:	SA Code:
Address:	
Telephone No.: ()	Fax No.: ()
Email Address:	

General Agent Name:	Fee or Commission %
License Number:	SA Code:
Address:	
Telephone No.: ()	Fax No.: ()
Email Address:	

SECTION VIII: AGREEMENT AND SIGNATURE**The group agrees to do the following:**

- Make payroll deductions, if employee contributions are required, and remit to Health Insurance Plan of New York the premiums payable in accordance with the terms of the Contract. Failure to pay on time could result in the termination of the group's coverage.
- Promptly notify Health Insurance Plan of New York of the termination or addition of any Member(s) covered or to be covered.
- Promptly provide Health Insurance Plan of New York with any information necessary to properly administer the coverage.
- Ensure compliance with ERISA/TEFRA/DEFRA/COBRA/OBRA and any other legislation pertaining to your group's coverage, as applicable.

It is understood that:

- If an acceptable employee enrollment form is received prior to the eligibility date, coverage will begin on the date of eligibility.
- If an acceptable employee enrollment form is received subsequent to the eligibility date, coverage will begin on the date of receipt
- All group applications are subject to approval by Health Insurance Plan of New York.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by Health Insurance Plan of New York, and will form a part of any Contract issued in reliance upon it. Acceptance of the group for coverage and the final rates are based upon the above information and the eligibility of the actual enrollees. Any material misrepresentation within this group application or the enrollee transaction and application form, whether intentional or unintentional, may cause termination of this coverage subject to the terms of the Contract. I understand and agree that it is my responsibility to offer coverage to all eligible employees and their dependents; and

I also understand that any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received. I am submitting a one (1) month premium deposit to be held without obligation until this application is approved. This premium deposit will be applied to the applicable premium billing/payment frequency I selected under this Contract. The premium deposit submitted with this application will be refunded if coverage does not become effective.

Subject to State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions if applicable may not be payable for up to eleven (11) months from the effective date of this Contract.

All statements in this application for coverage under a Contract for insurance shall be deemed representations and not warranties, and no such statements shall be used to deny a claim under the Contract, unless the statements are made in the application or in addenda attached to the Contract.

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 (5,000) dollars and the stated value of the claim for each such violation.

Signed at _____

On the _____ day of _____, 20_____

By: _____ Title: _____
(print name)

By: _____
(signature)

- Please return this completed application and the following items:
- *Employer's Quarterly Report of Wages Paid to Each Employee (NYS—45)*
 - Copy of a 12-month old (or more recent, if necessary) billing statement
 - First month's premium

To: **EmblemHealth**
New Business/Sales
55 Water Street
New York, NY 10041

EmblemHealth Website	(For EmblemHealth Office Use Only)	
For fast, convenient access to the latest claim status, eligibility, and benefits information, visit EmblemHealth's secure website at emblemhealth.com . Available around the clock, the site offers	Date Application Issued	(Initials)
	Date Application Received	_____
provider listings, enables you to order ID cards, view an online <u>Explanation of Benefits</u> , access wellness information, and much	Date Application Processed	_____
	Date, Contract and Copy of Application Sent	_____
Translation Services If English is not your primary language and translation services are needed when calling HIP Customer Service, a representative can help you.	Type of Plan	_____
	Group Number	_____
	Benefit Set ID	_____
	Effective Date	_____
	Rep ID	_____