

SMALL GROUP APPLICATION/CHANGE FORM (2-50 eligible employees) Thank you for choosing Empire. Please fill out all items below and www.empireblue.com print clearly in black or blue ink in order for us to quickly and Current Group Number (if applicable) accurately process your group's application. Once you've completed this form, please sign in the space provided in Section 11. 1. REASON FOR APPLICATION/CHANGE Requested Effective Date (MMDDYY) Revision or Renewal Date (MMDDYY) Change (fill in one only) Existing New **Benefits** Sales Representative Last Name First Name 2. GROUP INFORMATION Group Name (as it appears on documents attached) Doing Business As **Group Mailing Address** City State ZIP (5+4) County Phone Fax **Authorized Group Contacts** Primary Group Contact Last Name Primary Group Contact First Name Title

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## **4. GROUP ELIGIBILITY** Note: Eligible persons are defined as employees (on the group's payroll, K1, etc.) whose regular work schedule is at least 20 hours per week under this group contract.

Number of Employees	Eligibility Dates (complete both A & B)	Regions of Residence
(a) Number of employees at all locations (include owners and partners, exclude COBRA)*	A. Initial Enrollment of Group     All employees' and dependents' coverage will be in effect:      On Group Effective Date	If you are choosing HMO, Direct HMO, Empire Total Blues with HSA, Direct POS or DirectShare POS, please check all regions your enrolling employees reside in from the list below.
(b) Number of retirees eligible for coverage	After new employee eligibility is satisfied (see B)  All enrollment forms must be received no later than thirty (30) days following the new group effective date.	New York: Bronx, Kings, Queens, New York, Nassau, Rockland, Westchester, Richmond and Suffolk counties.
(c) Number of ineligible employees (check reason for ineligibility)	New Employees (after initial enrollment of group)     New employees will be eligible for coverage:     Date of hire	Mid-Hudson: Dutchess, Putnam, Orange, Sullivan and Ulster counties.
Other	First day following:  day(s) following date of hire	Albany: Albany, Clinton, Columbia, Delaware, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties.
(d) Number of net eligible	month(s) following date of hire; or	New Jersey Contiguous Counties: Bergen, Essex, Hudson, Middlesex, Monmouth, Passaic, Sussex and Union counties.
employees (a + b - c)  Number of enrolling employees (include retirees and COBRA)	First of the month following:  day(s) following date of hire	Connecticut Contiguous Counties: Fairfield and Litchfield counties.
Employer contribution to retiree coverage	month(s) following date of hire	
Have you ever employed more than 20 employees?  Yes No  If yes, please indicate the last year you had 20 or more employees  *Empire requires proof of employment (i.e., NYS-45, payroll, etc.)  See small group underwriting guidelines for more info	All enrollment forms must be received no later than sixty (60) days following the member's eligibility date.  C. Employee Reinstatement Policy Employees who are re-hired to the company are eligible for coverage:  Date of hire  Other  Please specify:	, , , , , , , , , , , , , , , , , , ,
5. PAYMENT SECTION Group's Cont % Employee only % 2-Party		6 Parent & Child(ren) % Family
If your group has multiple locations, do y	. ,	
Separate invoices for each location  If you are requesting quarterly billing, pla	A summary invoice combining all locations.  ease indicate here; otherwise, group will be billed monthly.	$\circ$

→ HMO*	$\circ$	Direct HMC	_	Direct PC	_	details under the co DirectShare <sup>™</sup> PC	-	PPO	○ EPO ○ Value EPO
Compi	rehensive Hos	oital/Medical	$\bigcirc$	Empire To	otal Blue <sup>sм</sup> w	ith HSA	Empire Pri	sm EPO	Other
HMO bene	fits provided by	/ Empire Hea	IthChoice H	MO, Inc.					
HMO /	DIRECT	HMO				Drescription	Drug (include	es contraceptives*	Rating Structure (fill in one only)
Please selec	ct only one pro	duct:	НМО	O Dire	ect HMO	•	ns (fill in one only		Training Structure (IIII III one only)
Co-payr	nent Opti	ons (fill in o	ne only)					Non-	2-Tier 3-Tier 4-T
Co-payment	Inpatient	PCP/Primary Home/Office	Specialist Home/Office		Ambulatory/ OP Surgery	Generic \$5	Brand \$20	Formulary \$40	Vision Option (fill in one only)
Options	Co-pay	Co-pay	Co-pay	Co-pay	Co-pay	\$10	\$20	\$40	Co-payment (fill in one)
Opt 2	\$0	\$10	\$10	\$35	\$0	\$10	\$25	\$50	
Opt 3	\$250/\$625*	\$10	\$10	\$35 ¢or	\$0 ¢o	\$10	\$35	\$70	
Opt 4	\$500/\$1,250*	\$15	\$15	\$35	\$0	\$10	50%	N/A <sup>†</sup>	Benefit cycle (fill in one)
Opt 5	\$0	\$20	\$20	\$35	\$0	\$15	N/A	N/A <sup>†</sup>	12-month 24-month
Opt 6	\$500/\$1,250*	\$20	\$20	\$35	\$0 ¢o	Deductible** (f	fill in one only)		Plan chaice (fill in and)
Opt 7	\$0 \$0	\$25 \$25	\$25 \$40	\$75 \$75	\$0 \$0	`	550 ( \$100	\$150	Plan choice (fill in one)
Opt 8	\$0 \$500/\$1,250*	\$25 \$25	\$40 \$40	\$75 \$75	\$0 \$75	\$250***	\$500***		Low (exam plus discounts)
Opt 9 Opt 10	\$500/\$1,250°° \$0	\$25 \$30	\$40 \$50	\$75 \$100	\$75 \$0	,	tion drug covera	ige	High (exam plus \$10 co-payment on
Opt 10	\$500	\$30	\$50 \$50	\$100	\$100	*Groups exempt fr	om purchasing cor	ntraceptives must	glasses/contacts and \$35 allow on non-plan frames)
Opt 12	\$1,000	\$30	\$50	\$150	\$150	attach a signed a	ffidavit.		No vision coverage
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per aumissi	on/family maxin	ium per caieno	uar year			† Mandatory \$0 d		Offiny	
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health Outpar health HMO / Please select Co-payr Co-payment Options Opt 2 Opt 3 Opt 4 Opt 5 Opt 6 Opt 7 Opt 8 Opt 9 Opt 10 Opt 11 Opt 12	care increases tient mental and care increases  DIRECT ct only one proment Option Inpatient Co-pay \$0 \$250/\$625* \$500/\$1,250* \$0 \$500/\$1,250* \$0 \$500/\$1,250*	from 30 to 45 I behavioral from 20 to 40  HMO duct: Ons (fill in or PCP/Primary Home/Office Co-pay \$10 \$15 \$20 \$25 \$25 \$25 \$25 \$30 \$30 \$30	visits  HMO ne only) Specialist Home/Office Co-pay \$10 \$10 \$15 \$20 \$25 \$40 \$40 \$50 \$50	**ER Co-pay \$35 \$35 \$35 \$35 \$35 \$75 \$75 \$100 \$100	from 60 t  Depende 19/23 to 19	Prescription Co-pay Option Generic \$5 \$10 \$10 \$10 \$15  Peductible** ( \$0 \$250*** ( No prescription) No prescription *Groups exempt for attach a signed at **Not applicable to	age increases from ndar year)  n Drug (includens (fill in one only)  \$20 \$20 \$25 \$35 50% N/A  fill in one only)  \$50 \$100 \$500***  otion drug coveration drug	sut  Wa  No  es contraceptives*  Non- Formulary \$40 \$40 \$50 \$70 N/A† N/A†  \$150  age  ntraceptives must  um.	A prior of the pre-existing conditions additional options    Rating Structure (fill in one only)
health Outpathealth HMO / Please select Co-payrent Options Opt 2 Opt 3 Opt 4 Opt 5 Opt 6 Opt 7 Opt 8 Opt 9 Opt 10 Opt 11 Opt 12	care increases tient mental and care increases  DIRECT et only one proment Option Inpatient Co-pay \$0 \$250/\$625* \$500/\$1,250* \$0 \$500/\$1,250* \$0 \$500/\$1,250*	from 30 to 45 I behavioral from 20 to 40  HMO duct:  Ons (fill in or PCP/Primary Home/Office Co-pay \$10 \$15 \$20 \$25 \$25 \$25 \$30 \$30 \$30 sum per calence	visits  HMO ne only) Specialist Home/Office Co-pay \$10 \$10 \$15 \$20 \$25 \$40 \$40 \$50 \$50 \$50 \$50 dar year	\$35 \$35 \$35 \$35 \$35 \$75 \$75 \$100 \$150	from 60 t  Depende 19/23 to  Pet HMO  Ambulatory/ OP Surgery Co-pay \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$150 \$150	Prescription Co-pay Option Generic \$5 \$10 \$10 \$10 \$10 \$15  Deductible** ( \$0 \$250*** ( No prescription) *Groups exempt for attach a signed at ***Not applicable with	age increases from ndar year)  n Drug (includens (fill in one only)  \$20 \$20 \$25 \$35 50% N/A  fill in one only)  \$50 \$100 \$500***  otion drug coveration drug	sut  Wa  No  es contraceptives*  Non- Formulary \$40 \$40 \$50 \$70 N/A† N/A†  \$150  age  ntraceptives must  um. only	Additional options    Rating Structure (fill in one only)   2-Tier
health Outpar health HMO / Please select Co-payr Co-payrent Options Opt 2 Opt 3 Opt 4 Opt 5 Opt 6 Opt 7 Opt 8 Opt 9 Opt 10 Opt 11 Opt 12 Per admission Miscella	care increases tient mental and care increases  DIRECT ct only one proment Option Inpatient Co-pay \$0 \$250/\$625* \$500/\$1,250* \$0 \$500/\$1,250* \$0 \$500/\$1,250*	from 30 to 45 I behavioral from 20 to 40  HMO duct: Ons (fill in or PCP/Primary Home/Office Co-pay \$10 \$15 \$20 \$25 \$25 \$25 \$30 \$30 \$30 sum per calence outlines (fill in the property in the page 20)	visits  HMO ne only) Specialist Home/Office Co-pay \$10 \$10 \$15 \$20 \$25 \$40 \$40 \$50 \$50 \$50 \$50 dar year	\$35 \$35 \$35 \$35 \$35 \$75 \$75 \$100 \$150	from 60 t  Depende 19/23 to 19	Prescription Co-pay Option Generic \$5 \$10 \$10 \$10 \$10 \$10 \$10 \$10 \$10 \$10 \$10	age increases from ndar year)  n Drug (includens (fill in one only)  Brand \$20 \$20 \$25 \$35 50% N/A  fill in one only) \$50 \$100 \$500***  otion drug coveration	sut  Wa  No  es contraceptives*  Non- Formulary \$40 \$40 \$50 \$70 N/A† N/A†  \$150  age  ntraceptives must  um. only	additional options    Rating Structure (fill in one only)   2-Tier   3-Tier   4-T   Vision Option (fill in one only)   Co-payment (fill in one)   \$5
health Outpar health HMO / Please select Co-payr Co-payrent Options Opt 2 Opt 3 Opt 4 Opt 5 Opt 6 Opt 7 Opt 8 Opt 9 Opt 10 Opt 11 Opt 112 Opt 12 Opt 13 Opt 14 Opt 15 Opt 16 Opt 17 Opt 18 Opt 19 Opt 10 Opt 11 Opt 11	care increases tient mental and care increases  DIRECT ct only one proment Option Inpatient Co-pay \$0 \$250/\$625* \$500/\$1,250* \$0 \$500/\$1,250* \$0 \$500/\$1,250* \$0 \$500 \$1,000 con/family maxim	from 30 to 45 I behavioral from 20 to 40  HMO duct:  Ons (fill in or PCP/Primary Home/Office Co-pay \$10 \$10 \$15 \$20 \$25 \$25 \$25 \$30 \$30 \$30 sum per calence obtions (fill in the policy of the payment of	HMO ne only) Specialist Home/Office Co-pay \$10 \$10 \$15 \$20 \$25 \$40 \$40 \$50 \$50 \$50 dar year	\$35 \$35 \$35 \$35 \$35 \$75 \$75 \$100 \$150	from 60 t  Depende 19/23 to 19	Prescription Co-pay Option Generic \$5 \$10 \$10 \$10 \$10 \$15  Deductible** ( \$0 \$250*** ( No prescription of the strength of the	age increases from ndar year)  n Drug (includens (fill in one only)  Brand \$20 \$20 \$25 \$35 50% N/A  fill in one only) \$50 \$100 \$500***  otion drug coveration	sut  Wa  No  es contraceptives*  Non- Formulary \$40 \$40 \$50 \$70 N/A† N/A†  \$150  age  ntraceptives must  um. only  Inp. sut	Additional options    Rating Structure (fill in one only)   2-Tier
health Outpathealth Outpathealth Outpathealth  Please select Co-payr Co-payment Options Opt 2 Opt 3 Opt 4 Opt 5 Opt 6 Opt 7 Opt 8 Opt 9 Opt 10 Opt 11 Opt 12 per admission  Miscella Inpatichealth Outpati	care increases tient mental and care increases  DIRECT ct only one proment Option Inpatient Co-pay \$0 \$250/\$625* \$500/\$1,250* \$0 \$500/\$1,250* \$0 \$500/\$1,250*  con/family maximum cous Opent mental and	from 30 to 45 I behavioral from 20 to 40  HMO duct: Ons (fill in or PCP/Primary Home/Office Co-pay \$10 \$15 \$20 \$25 \$25 \$25 \$30 \$30 \$30 \$30 sum per calence of the positions (fill in or any per calence of the positions) behavioral if from 30 to 45 I behavioral	visits  HMO ne only) Specialist Home/Office Co-pay \$10 \$10 \$15 \$20 \$20 \$25 \$40 \$40 \$50 \$50 \$50 \$50 dar year	\$35 \$35 \$35 \$35 \$35 \$75 \$75 \$100 \$150	from 60 t  Depende 19/23 to  Pet HMO  Ambulatory/ OP Surgery Co-pay \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$150 \$150  Options you w  Skilled no 60 to 120 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	Prescription Co-pay Option Generic \$5 \$10 \$10 \$10 \$10 \$15  Deductible** ( \$0 \$250*** ( No prescription of the strength of the	age increases from ndar year)  n Drug (includens (fill in one only)  Brand \$20 \$25 \$35 50% N/A  fill in one only) \$50 \$100 \$500***  otion drug coveration drug	sut  Wa  No  es contraceptives*  Non- Formulary \$40 \$40 \$50 \$70 N/A† N/A†  \$150  age  ntraceptives must  im. only  Unp sut	Additional options    Rating Structure (fill in one only)   2-Tier

## EMPIRE TOTAL BLUE<sup>SM</sup> COVERAGE W/ HSA OPTIONS

		In-N	letwork		ı	Out-	of-Network	
Option	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Maximum	Coinsurance Out-of-Pocket Maximum Individual/Family	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Individual/Family	Coinsurance Out-of-Pocket Maximum Individual/Family
<u> </u>	\$1,250/ \$2,500	80/20%	\$10,000/ \$20,000	\$2,000/ \$4,000	\$5,000/ \$10,000	60/40%	\$25,000/ \$50,000	\$10,000/ \$20,000
<u>2</u>	\$1,500/ \$3,000	80/20%	\$17,500/ \$35,000	\$3,500/ \$7,000	\$3,000/ \$6,000	60/40%	\$17,500/ \$35,000	\$7,000/ \$14,000
<u>3</u>	\$2,000/ \$4,000	80/20%	\$15,000/ \$30,000	\$3,000/ \$6,000	\$3,500/ \$7,000	60/40%	\$17,500/ \$35,000	\$7,000/ \$14,000
<u> </u>	\$2,000/ \$4,000	80/20%	\$15,000/ \$30,000	\$3,000/ \$6,000	\$10,000/ \$20,000	50/50%	\$40,000/ \$80,000	\$20,000/ \$40,000
<u> </u>	\$2,500/ \$5,000	80/20%	\$12,500/ \$25,000	\$2,500/ \$5,000	\$4,500/ \$9,000	60/40%	\$20,000/ \$40,000	\$8,000/ \$16,000
<u>6</u>	\$3,000/ \$6,000	80/20%	\$10,000/ \$20,000	\$2,000/ \$4,000	\$10,000/ \$20,000	50/50%	\$40,000/ \$80,000	\$20,000/ \$40,000
7	\$5,000/ \$10,000	100%	N/A	N/A	\$10,000/ \$20,000	70/30%	\$66,667/ \$133,334	\$20,000/ \$40,000
8	\$3,000/ \$6,000	100%	N/A	N/A	\$6,000/ \$12,000	60/40%	\$30,000/ \$60,000	\$12,000/ \$24,000
Dr *Rx Co-I	pays do not apply to	Options 7 and 8	but drug option	ulary \$50 after deductible* must be selected to receiv st submit a signed affidavit	e coverage	ceptives**)	O No Drug	Coverage at all
Vision	Option (fill in c	one only)			Plan choice (fi	I in one)		
	ment (fill in one)		\$10		O Low (exam	plus discounts)		
Benefit	cycle (fill in one)	12-month	24-mor	nth	<u> </u>		ment on glasses/ on non-plan frames	·)
					O No vision o	overage		
(check a	llaneous Opt Il of the following to purchase)		increases	nt children/student age from 19/23 to 23/25 alendar year)	alcohol/sub	habilitation for stance abuse— mbined in-networl network	butD c facili	up will establish HSA, OES NOT want Empire to tate additional options
DIRE	CT POS CO	VERAGE	OPTION	S	 I			

	In-Network PCP/Primary Specialist						Out-of	f-Network	
0	Option 1	PCP/Primary Home/Office Co-payment \$15	Specialist Home/Office Co-payment \$15	Inpatient Co-payment \$0		Deductible dividual/Family \$500/\$1,250	Coinsurance 70%/30%	Coinsurance Stop Loss Individual/Family \$10,000/\$25,000	Coinsurance Out-of-Pocket Maximum Individual/Family \$3,000/\$7,500
$\bigcirc$	Option 2	\$15	\$15	\$250/\$625*		\$500/\$1,250	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
$\bigcirc$	Option 3	\$20	\$20	\$0	\$	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
$\bigcirc$	Option 4	\$20	\$20	\$250/\$625*	\$	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
$\bigcirc$	Option 5	\$20	\$20	\$500/\$1,250*	\$	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
$\bigcirc$	Option 6	\$20	\$20	\$0	\$	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
$\bigcirc$	Option 7	\$20	\$20	\$250/\$625*	\$	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
$\bigcirc$	Option 8	\$20	\$20	\$500/\$1,250*	\$	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
$\bigcirc$	Option 9	\$15	\$15	\$0	\$	\$2,000/\$5,000	60%/40%	\$15,000/\$37,500	\$6,000/\$15,000
$\bigcirc$	Option 10	\$15	\$15	\$500/\$1,250*	\$	\$2,000/\$5,000	60%/40%	\$15,000/\$37,500	\$6,000/\$15,000
$\bigcirc$	Option 11	\$20	\$20	\$0	\$	\$2,000/\$5,000	60%/40%	\$20,000/\$50,000	\$8,000/\$20,000
$\bigcirc$	Option 12	\$20	\$20	\$500/\$1,250*	\$	\$2,000/\$5,000	60%/40%	\$20,000/\$50,000	\$8,000/\$20,000
$\bigcirc$	Option 13	\$25	\$40	\$0	\$	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
$\bigcirc$	Option 14	\$25	\$40	\$0	\$	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
$\bigcirc$	Option 15	\$25	\$40	\$0	\$	\$2,000/\$5,000	60%/40%	\$20,000/\$50,000	\$8,000/\$20,000
$\bigcirc$	Option 16	\$25	\$40	\$500/\$1,250*	\$	\$2,000/\$5,000	60%/40%	\$15,000/\$37,500	\$6,000/\$15,000
Out	of Network UC	CR Option (Usual, C	Customary and Re	easonable Fee Reimbu	rsement)	70%	0 80%		

Note: ER co-pay: Options 1–12 — \$50 Options 13–16 — \$75 Ambulatory/OP Surgery co-pay: Option 16 — \$75 \*per admission/family maximum per calendar year

Vision Option (fill in one only)		ption Dru Options (fill in	(includes contra	aceptives*)	Deductible <sup>3</sup>	* (fill in one	only)
Co-payment (fill in one) \$5 \$10	Gener			.,	<b>\$0</b>	\$50	\$100
Benefit cycle (fill in one)	\$5	ic Brand \$20	Non-Formular \$40	у	0450		O 0500
12-month 24-month	\$10	\$20	\$40		\$150	\$250	\$500
Plan choice (fill in one)	\$10	\$25	\$50		O No preso	ription drug co	overage
Low (exam plus discounts)	\$10	\$35	\$70			pt from purchasi signed affidavit	ng contraceptives
High (exam plus \$10 co-payment on glasses/			·			e to mail-order p	
contacts and \$35 allowance on non-plan frames)  No vision coverage	\$10	50%	N/A <sup>†</sup>		† Mandatory \$0	deductible	
	\$15	N/A	N/A <sup>†</sup>				
(check all of the following options you wish to purchase) increas	dent children/student age ses from 19/23 to 23/25 (e ndar year)	end	Inpatient rehabilitat alcohol/substance 30 days combined and out-of-network	abuse— in-network	С	Jaiver for pre-conditions	J
DIRECTSHARE <sup>™</sup> POS OPTIONS	Co-payment Opt	ions (fill in o	ne only)				
	-Network				Out	-of-Netwo	ork
PCP/Primary Specialist Home/Office Home/Office In-patient Co-Pay Co-Pay Co-Pay* D	Deductible* Coinsurance*	Coinsurance Stop Loss*	Out-of-Pocket Coinsurance Max*	Deductible*	Coinsurance	Coinsurance Stop Loss*	Out-of-pocket Coinsurance Ma
Option 1 \$25 \$40 Ded + Coins	\$ 250 90%/10%	\$10,000	\$1,000	\$1,500	70%/30%	\$10,000	\$3,000
Option 2 \$30 \$50 Ded + Coins	\$ 500 90%/10%	\$10,000	\$1,000	\$1,000	70%/30%	\$10,000	\$3,000
Option 3 \$30 \$50 Ded + Coins	\$ 500 80%/20%	\$10,000	\$2,000	\$1,000	60%/40%	\$10,000	\$4,000
Option 4 \$30 \$50 Ded + Coins	\$ 750 80%/20%	\$12,500	\$2,500	\$1,500	60%/40%	\$12,500	\$5,000
Option 5 \$30 \$50 Ded + Coins	\$1,000 80%/20%	\$15,000	\$3,000	\$2,000	60%/40%	\$15,000	\$6,000
Out of Network UCR Option (Usual, Customary and Reason	onable Fee Reimburseme	ent) (	70% ( 80	l%			
Note: ER co-pay \$75 *Family coverage is 2.5 times the ind	lividual coverage amount.						
Vision Option (fill in one only)	Prescription Dr	'U <b>g</b> (includes	contraceptives*)	Deductil	ole** (fill in one	e only)	
Co-payment (fill in one) \$5 \$10	Co-pay Options (fill	in one only)		<b>\$</b> 0	\$50	\$100	
Benefit cycle (fill in one)	Generic Brand	Non-For	mulary	O 40	Φ Φ00	<b>O</b> \$100	
12-month 24-month	\$10 \$20	\$40	0	\$150	\$250	\$500	
Plan choice (fill in one)	\$10 \$30	\$50	0	_	<b>O</b> , 33	<b>O V I I I I I I I I I I</b>	
Low (exam plus discounts)	\$10 \$35	\$70	0	O No pi	rescription drug	coverage	
High (exam plus \$10 co-payment on glasses/	\$10 50%	N/A	,†		exempt from purchatch a signed affidat		ives
contacts and \$35 allowance on non-plan frames)  No vision coverage	\$15 N/A	N/A	†		cable to mail-order y \$0 deductible	program.	
(check all of the following options increas	dent children/student age ses from 19/23 to 23/25 (en ar year)		Inpatient rehabilitati stance abuse—30 onetwork and out-of-	days combined	d in-	Vaiver for pre-econditions	o .
_							

#### 6. MEDICAL BENEFITS SECTION (continued) **EPO COVERAGE OPTIONS** In-Network Options (fill in one only) Office Visit Co-payment \$20 \$30 Vision Co-payment (fill in one only) Prescription Drug (includes contraceptives\*) Deductible\*\* (fill in one only) Co-pay Options (fill in one only) Low \$5 Co-payment (1 exam every 24 months) \$100 \$50 Generic Brand Non-Formulary High \$5 Co-payment (1 exam every 24 months) \$10 \$20 \$40 No prescription drug coverage \$10 Co-payment for frames \$150 \$25 Co-payment for contact lenses \* Groups exempt from purchasing contraceptives \$10 \$25 \$50 \$35 Allowance for non-plan frames must attach a signed affidavit. \*\* Not applicable to mail-order program. Miscellaneous Options Dependent children/student age Inpatient rehabilitation for No additional options (fill in all of the following options increases from 19/23 to 23/25 alcohol/substance abuse you wish to purchase) (end of calendar year) 30 days combined in-network VALUE EPO OPTIONS Co-payment Options (fill in one only) In-Network PCP/Primary Specialist Home/Office Home/Office Out-of-Pocket In-patient Coinsurance Co-Pay Deductible Co-Pav Coinsurance Coinsurance Max\* Co-Pav Stop Loss' Option 1 \$30 \$30 Ded + Coins \$1,000 90%/10% \$10,000 \$1,000 Option 2 Ded + Coins 90%/10% \$10,000 \$1,000 \$30 \$30 \$1,500 Option 3 \$30 \$30 Ded + Coins \$2,000 80%/20% \$10,000 \$2,000 \$4,000 Option 4 \$30 \$30 Ded + Coins \$500 80%/20% \$20,000 Option 5 Ded + Coins 80%/20% \$10,000 \$2,000 \$30 \$30 \$3.000 \*Family coverage is 2.5 times the individual coverage amount. Note: ER co-pay \$100 Vision Option (fill in one only) Prescription Drug (includes contraceptives\*) Deductible\*\* (fill in one only) Co-pay Options (fill in one only) Co-payment (fill in one) \$5 \$10 \$100 \$50 Benefit cycle (fill in one) Non-Formulary Generic Brand \$150 \$250 \$500 12-month 24-month \$10 \$25 \$50 Plan choice (fill in one) No prescription drug coverage \$10 \$35 \$70 Low (exam plus discounts) \*Groups exempt from purchasing contraceptives

#### Miscellaneous Options

No vision coverage

(check all of the following options you wish to purchase)

High (exam plus \$10 co-payment on glasses/

contacts and \$35 allowance on non-plan frames)

Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)

\$10

\$10

50%

N/A

- 4th Quarter Deductible Carry Over
- Inpatient rehabilitation for alcohol/substance abuse—30 days combined innetwork and out-of-network

must attach a signed affidavit

\*\* Not applicable to mail-order program.

† Mandatory \$0 deductible

No additional options

N/A<sup>†</sup>

N/A<sup>†</sup>

PPO COVERAGE In-Network Options		/isit Co-payment (	) \$12	\$30	
Out-of-Network Op		. ,			
	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Individual/Family	Coinsurance Out-of-Pocket Maximum Individual/Family	
<u> </u>	\$500/\$1,250	70%/30%	\$5,000/\$12,500	\$1,500/\$3,750	
<u> </u>	\$500/\$1,250	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500	
○ 3	\$750/\$1,875	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250	
<u> </u>	\$1,000/\$2,500	70%/30%	\$25,000/\$62,500	\$7,500/\$18,750	
High \$5 Co-payment ( \$10 Co-payment \$25 Co-payment	(1 exam every 24 months) 1 exam every 24 months)	Prescription Drug Co-pay Options (fill in Generic Brand \$10 \$20 \$10 \$25		Deductible** (fill in one only)  \$0 \$50 \$100  \$150 No prescription drug cov  * Groups exempt from purchasing contraceptives must attach a signed affidavit.  ** Not applicable to mail-order program.	· verage
Miscellaneous Opti (fill in all of the following opti you wish to purchase)	ons increase	ent children/student age ss from 19/23 to 23/25 calendar year)	Inpatient rehabilita alcohol/substance 30 days combined	abuse—	-
Deductible, Coinsu Check the deductible you desi Annual Deductible (Individual/Family)	Options: Coinsurance a (Individual/Family)	Options w. Then move to the right of you and Stop Loss		oinsurance and stop-loss level you wish (fill in one only).	
\$200/\$500	80% Coinsurance to \$2,000/\$5,000 Stop Los	80% Coinsurance t s \$4,000/\$10,000 Sto	•	oinsurance with o Loss	
\$500/\$1,000	80% Coinsurance to \$2,000/\$5,000 Stop Los	80% Coinsurance t \$4,000/\$10,000 Sto			-
\$1,000/\$2,000	80% Coinsurance to \$4,000/\$10,000 Stop Los	S			•
Rating Structure (f	ill in one only)	2-Tier	4-Tier		•
Miscellaneous Op	tions (fill in all of the following	g options you wish to purchas	se)		-
Alcohol and substance a detox and 30 days inpaticalendar year	ent rehab per (\$10,000 pe \$50,000 pe	r nursing er year maximum; r lifetime maximum)  college student age 25 end of calendar year	Nonpar hospital paid as p  Speech and occupational unlimited visits	(7 outpatient visits per person per	
1		I		ENR6000BPB08	I

#### **EMPIRE PRISM EPO OPTIONS**

Select the following new Copay Options and prescription drug card choice if applicable.

#### Co-payment Options (fill in one only)

Co-Payment options	Inpatient Co-Pay	PCP/Primary Home/Office Co-Pay	Specialist Home/Office Co-Pay	ER Co-Pay	Ambulatory/ OP Surgery Co-Pay
Option 1	\$200/\$500*	\$25	\$25	\$100	\$150
Option 2	\$500/\$1,250*	\$35	\$35	\$100	\$300

<sup>\*</sup> per admission/family maximum per calendar year

Prescription D	rug	(includes	contraceptives)
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 Co-pay Options (fill in one only)

 Generic
 Brand
 Non-Formulary

 \$10
 \$35
 \$70\*

 \$10
 \$35
 \$70 (\$2,000 max)

 \$10
 50%
 N/A†

 \$15
 N/A
 N/A†

Deductible	(fill	in	one	only)
O \$0				O \$50

\$100 \$250

\*\$0 Deductible not Allowed
†Mandatory \$0 Deductible.

\$500

<b>Rating Structure</b>	(fill	in	one	only)
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- 2-Tier (Upstate & Mid-Hudson regions)
- 3-Tier (Upstate & Mid-Hudson regions)
- 4-Tier (All rating regions)

#### Vision Option (fill in one only)

Plan Choice (fill in one)

- O Low (exam plus discounts)
- O High (exam plus \$10 co-payment on glasses/contacts and \$35 allowance on non-plan frames)
- O No vision coverage

### Miscellaneous Options

(fill in all of the following options you wish to purchase)

- Dependent children/student age increase from 19/23 to 23/25 (end of calendar year)
- Inpatient rehabilitation for alcohol/substance abuse 30 days in-network

o Coverage													
remium Ca	re PPO												
oinsurance n-Network	Coinsurance Out-of-Network	-			ment on o	iagnos	tic and	0	Age 23/25 Rider				
0%/80%/50%	100%/80%/50%		•	-	Basic Res	torative	coverage						
00//200/ /500/	800/ Jeno/ Jeno/	O Compr	ehensive Care	•				0	Open Acce		ntary		
			Plan 1	$\bigcirc$	Plan 2	$\bigcirc$	Plan 3		Coinsurance	Deductible	Orthodontics**		
ole (fill in one onl	y)	o	ffice visit co-pa	ays					100%/50%/50%	\$25	Child only		
5/\$75	\$50/\$150		\$0	$\bigcirc$	\$5	$\bigcirc$	\$10						
Maximum (fill in	one only)	0	rthodontics**					0	100%/50%/30%	\$50	Not Available		
,000	\$1,500		,			l adult		_					
		0		ax per m		_			100%/50%/0%	\$50	Not Available		
thodontics**			\$2,000	0	\$2,500	$\circ$	\$3,000			Representative	for availability of		
t your Sales repre	sentative for	D	_		60 11				1				
mity of this option.		* Evicting ar-					alection		+	_			
		W	0/ 5	mploy-	a & Snove		0/ D	int 9 O	uld(ren)	% Family			
pioyee only	% 2 Part	у	% E	inpioye	e & Spouse		% Pare	ent & Cl	iliu(ren)	% Family			
								$\perp$					
COVERSOR													
ir group currently h	•		s No	It	f yes, Insur	ance Ca	ırrier						
carrier, including E	Empire?	<u> </u>	<u> </u>	Γ	,,oui	00	<del>-</del>	$\top$					
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## 8. PLEASE ATTACH COPY OF RATE PROPOSALS

## 9. AGENT/BROKER DECLARATION AND INFORMATION

To the best of my knowledge, all the statements/responses in this application are true and complete. I have no knowledge about the Applicant, his/her employees, the dependents of such employees or an individual who is receiving continuation of coverage under federal or state laws which is not fully stated in this application.

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The Personnel Record and the attached complete copy of my New York State Department of Taxation and Finance "Quarterly Combined Withholding and Wage Reporting return of Wages Paid to each Employee (NYS-4/NYS-45/NYS-45ATT)" as filed, signed by an officer or owner of the group, W-2 forms or any additional documentation validating enrollment of employees, owners or partners (i.e., K-1, notarized statements, payroll records) are a completed statement of the total number of our employees, including the reasons why any individuals are not being covered, for which appropriate documentation is submitted.

For eligible retirees, evidence of past employment and continuing financial arrangements is required.

If the enrollment forms submitted meet Empire's credentialing and eligibility requirements, and are in compliance with New York State law, and we issue coverage, the group agrees to the following:

Remit to Empire the charges payable in accordance with the terms of such contracts, and if employee contributions are required, make necessary payroll deductions; group must also submit payment promptly, not to be received after the expiration of the grace period. (Failure to pay promptly will result in the

termination of the group's coverage.) Empire must be allowed to audit and/or make copies of any records or information that relate to the administration of this coverage.

Ensure compliance with HIPAA (45 CFR Parts 160–164) as it relates to health plans. Ensure compliance with TEFRA / DEFRA / COBRA / OBRA legislation as it relates to any active employee or dependent of an active employee who elects the group's benefits as primary. Ensure prompt conversion to Medicare-related / Carveout coverage of Medicare-eligible actively employed group members and dependents not covered by TEFRA / DEFRA / OBRA legislation. Ensure prompt conversion to Medicare-related / Carveout coverage for eligible Medicare retirees.

Promptly submit an employee's enrollment form for eligible members only and promptly remove members who are no longer eligible. Failure to report removals promptly could result in the group being responsible for premiums or claims paid subsequent to the employee's removal date. The group must also ensure all employees enroll in accordance with their marital status.

If an acceptable enrollment form is received prior to or within 60 days after the eligibility date, coverage will

begin on the date of eligibility; otherwise, coverage will begin on open enrollment or the next group renewal date.

Benefits purchased and established eligibility selected may be changed at renewal only. It is understood that this agreement may be terminated by the group giving 30 days' prior written notice. In the event of termination by the group, the group will be required to pay premiums to a date not less than 60 days subsequent to the written notification by the group to Empire. Empire may terminate this agreement for any of the reasons set forth in the group contract. This group application is a part of the agreement between Empire and the group for health insurance benefits.

New York insurance law requires that your employees who receive health coverage from an HMO, Direct HMO or Direct POS health plan, be given 30 days' prior notice when an increase in the group insurance premium rates results in an increase to their premium contributions. Employers offering other types of health coverage are also encouraged to provide this information to their employees. For more information and to download a sample employee notification letter, visit www.empireblue.com.

# 10. SIGNATURE OF AUTHORIZED REPRESENTATIVE — I HAVE READ THIS ENTIRE APPLICATION AND THE CERTIFICATION AND FRAUD STATEMENT.

Group hereby designates the broker(s) listed on this application as the broker(s) of record for the Group (the "BOR"), and agrees that notice to the BOR constitutes notice to the Group. Further, that the Group has agreed that the BOR will be paid the commission specified in #9 above in compliance with Empire's applicable commission schedule. Further the Group agrees that the BOR designation and the commission rate will continue until expressly terminated in writing by the Group.

The commission rate or other compensation that may be received by your broker does not change your premium rate. Small group brokers who provide specific additional administrative services may also receive an additional payment from Empire. You can obtain additional information regarding Empire's standard commission scale applicable to your product and any applicable broker compensation programs by visiting **www.empireblue.com** or by contacting your Empire representative.

Authorized Group Signature	Date	(MMDI	DYY)		
Print Last Name Print First Name					
Title					

#### **INSURANCE FRAUD STATEMENT**

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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.



#### 11. OPTIONAL EMPLOYER ONLINE SERVICES DELEGATION FORM

Empire BlueCross BlueShield is offering Group Benefit Administrators an opportunity to delegate the administration of their accounts to their Broker of Record. The Broker of Record will perform the administrative duties assigned to him or her by the Group Benefits Administrator via Empire's secure Broker Online Services web site at **www.empireblue.com**.

Please complete this form and the Terms and Conditions Letter Agreement (the "Agreement") if you would like to permit your Broker of Record to administer your account for you. Please be sure to discuss this delegation with your broker prior to submission.

#### Please mail or fax this form to:

Broker Relations 15 MetroTech Center, 4th Fl. Brooklyn, NY 11201 Fax: 1-718-312- 6006

Please note: By filling out this form and the Agreement and giving your Broker of Record access to manage your account, you are not giving up your right to access your account through Employer Online Services or to administer your account.

	Please check if you would like to:												Please check all activities that you would like to delegate to your Broker of Record:																
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<sup>\*</sup> You will not be able to assign a new Broker of Record using this form. Please check the box only if you would like to terminate your current Broker of Record's administrative rights.

## 11. TERMS AND CONDITIONS LETTER AGREEMENT FOR ACCESS TO THE EMPIRE EMPLOYER ONLINE DELEGATION

This Terms and Conditions Letter Agreement (the "Agreement") sets forth the understandings and agreement between

\_ ("the Group") and Empire HealthChoice Assurance, Inc., d/b/a Empire

(continued)

BlueCross BlueShield and Empire HealthChoice HMO, Inc., d/b/a Empire BlueCross BlueShield HMO (together referred to as "Empire"), to permit access to Empire's interactive Employer Online Services web site ("web site") for use by the Broker of Record, or an authorized designee of the Broker of Record (together referred to as "brokers"), designated by the Group, to facilitate the administration of the health benefit plan(s) (the "plan(s)") purchased by the Group from Empire pursuant to a separate Contract (the "Contract").

The Group understands and agrees that access to the web site granted by Group to its designated brokers is subject to the following terms and conditions:

- 1. Empire shall provide those brokers designated by the Group access to the Employer Online Services web site in accordance with Empire's registration procedures. The Group understands that all designated brokers must agree to the web site Terms and Conditions.
- 2. The Group understands that the purpose of this web site is to provide an additional medium for the Group, through its designated brokers, to carry out the certain plan administration functions as delegated by the Group, including the ability to: maintain eligibility files, process enrollment and enrollment changes for members and dependents, select and change PCPs on behalf of and at the request of a member, search for participating providers, view certain claims information on behalf of and at the request of a member, request ID cards and print temporary cards, maintain and update COB information, and view statements of account(s), access billing reports, pay and/or adjust bills, and other functions as may be added from time to time by Empire and delegated by the Group.
- 3. The Group is solely responsible for the accuracy and authenticity of the information submitted on the web site.
- 4. This agreement relates solely to access by the brokers designated by the Group to the web site and does not add, diminish or otherwise change the obligations of the parties, which remain subject to the Contract, any other agreements executed by the parties, the contracts of health insurance coverage issued by Empire, and Empire policies and procedures. In the event of a conflict between this agreement and any of the aforementioned, the aforementioned shall control.
- 5. The Group shall advise Empire, in writing, of the names and other information as requested by Empire, of its brokers who shall have web site access, and shall timely notify Empire of brokers who no longer are authorized to access the web site. Notice shall be sent by fax to 1-718-312-6006.
- 6. Any data accessed and/or provided to the Group or to its brokers on the web site shall remain the property of Empire.
- 7. Empire is not responsible for the accuracy and completeness of records supplied to Empire by the Group, the brokers or by health care providers.
- 8. The Group and its representatives shall maintain and preserve the confidential and proprietary nature of all Empire's data to which the Group and its representatives have access. The Group shall not provide either web site access, or other access to Empire's proprietary and confidential information available to the Group on the web site, to any unauthorized party, or in a manner in conflict with this Agreement.
- 9. The Group will hold Empire, its officers, directors and agents, harmless from any loss, expense, liability, claim, lawsuit or judgement (including reasonable attorneys' fees) arising directly or indirectly out of Empire's disclosure of the Group's enrollment and/or claims information or from the Group's provision to Empire of enrollment information, or resulting from the Group's failure to abide by the terms of this Agreement.
- 10. The obligations undertaken herein in Paragraphs 8 and 9 above shall survive the expiration or termination of this Agreement.
- 11. Nothing contained in this Agreement shall be construed as granting or conferring any rights by license, patent, copyright or any other intellectual property right of one party to the other.
- 12. This Agreement shall terminate:
  - a. by Empire or the Group upon five (5) business days written notice by facsimile transmission, or otherwise, or as otherwise agreed to by the parties hereto in writing;
  - b. if prohibited by any law or regulation;
  - c. six (6) months after the termination of the Contract.
- 13. If the Group has more than one health benefits plan under the terms of its Contract, the Group's designated brokers shall have access, if such access is delegated to the brokers, to any of its health benefits plans that may terminate during the term of the Contract, for the earlier of twenty-four (24) months after termination of the specific health benefits plan or six (6) months after the termination of the Contract.

Please sign and date this Agreement in the space provided below to confirm your agreement to these terms and conditions, and return the fully executed original at your earliest convenience.

Sincerely.

Mark Wagar President

Acknowledged and Agreed to									
This day of	, 200								
Print Name:									
Signature:									

## **NEW RIDER SELECTION WORKSHEET**

(2-50 Eligible Employees)

O No Selection

Domestic Partner Rider Selection													
New Small Groups are defaulted to Same & Opposite Sex domestic partnership coverage unless otherwise specified.  Please make a selection to choose a different form of Coverage.  O Same Sex Only  No Domestic Partnership Coverage													
Product I Please choose the product for which you request a rider addition:													
○ HMO	O Direct POS	○ PPO	○ Value EPO	○ Empire Total Blue <sup>SM</sup>									
O Direct HMO	○ DirectShare <sup>SM</sup> POS	○ EPO	○ Empire Prism <sup>SM</sup> EF	PO Other									
Rider Selection:  O Biologically Based Mental Illness and Serious Emotional Disturbances Coverage  O No Selection													
Product II Please choose the product for which you request a rider addition:  ○ HMO ○ Direct POS ○ PPO ○ Value EPO ○ Empire Total Blue <sup>SM</sup>													
O Direct HMO	○ DirectShare <sup>SM</sup> POS	○ EPO	○ Empire Prism <sup>SM</sup> EF	PO Other									
- 0,	ed Mental Illness and Seric	ous Emotional D	isturbances Coverage										
O No Selection													
Product III Please choose t  OHMO	Please choose the product for which you request a rider addition:												
O Direct HMO	○ DirectShare <sup>SM</sup> POS	ОЕРО	○ Empire Prism <sup>SM</sup> EF	PO Other									
Rider Selection:													
O Biologically Base	O Biologically Based Mental Illness and Serious Emotional Disturbances Coverage												