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 Insurance Company 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 ☐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 Full-Time Equivalent (FTE) 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)

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 (Individual/Family)	☐$0 ☐$500/$1,000 ☐$1,000/$2,000 ☐$1,500/$3,000 ☐$2,000/$4,000 ☐$2,500/$5,000 ☐$3,000/$6,000 ☐$3,500/$7,000
Prescription drug deductible (Individual/Family)	☐$0 ☐$100/$200
Medical coinsurance	☐0% ☐10% ☐20% ☐30%
Plan year out-of-pocket max (Individual/Family)	☐$4,000 / $8,000 ☐$4,500 / $9,000 ☐$5,000 / $10,000 ☐$6,000 / $12,000 ☐$7,150 / $14,300
PCP office visit	☐$20 ☐$25 ☐$30 ☐$40 ☐$50 ☐$60
Specialist office visit	☐$20 ☐$25 ☐$30 ☐$40 ☐$50 ☐$60 ☐$65 ☐$75
Inpatient hospital admission	☐$250 ☐$500 ☐$1,000 ☐Subject to deductible and coinsurance
Ambulatory surgery center facility	☐$100 ☐$150 ☐$200 ☐$250 ☐$350 ☐$400
Outpatient hospital surgery facility	☐$150 ☐$200 ☐$250 ☐$350 ☐$400 ☐$600
Emergency room	☐$100 ☐$150 ☐$200 ☐$250
Urgent care center	☐$50 ☐$60 ☐$75 ☐$100
Ambulance	☐$100 ☐$150 ☐$200 ☐$250
Prescription Drug Options	☐$15 Preferred Generic/$30 Preferred Brand Name/$50 Non-Preferred ☐$15 Preferred Generic/$30 Preferred Brand Name/$75 Non-Preferred; all tiers subject to deductible ☐$15 Preferred Generic/$35 Preferred Brand Name/$75 Non-Preferred; all tiers subject to deductible ☐$20 Preferred Generic/$40 Preferred Brand Name/$100 Non-Preferred; all tiers subject to deductible
Outpatient mental health care	☐$20 ☐$25 ☐$30 ☐$40 ☐$50 ☐$60
Outpatient substance use care	☐$20 ☐$25 ☐$30 ☐$40 ☐$50 ☐$60
Outpatient habilitation services	☐$20 ☐$25 ☐$30 ☐$40 ☐$50 ☐$60 ☐$65 ☐$75
Outpatient rehabilitation services	☐$20 ☐$25 ☐$30 ☐$40 ☐$50 ☐$60 ☐$65 ☐$75
Diabetic supplies	☐$20 ☐$25 ☐$30 ☐$40 ☐$50 ☐$60
Durable medical equipment	☐Covered in full

SECTION IV: COPAYMENT/BENEFIT OPTIONS (Select one from each category) - continued	
Dialysis treatment	In PCP Office □$20 □$25 □$30 □$40 □$50 □$60 Other Outpatient locations □$20 □$25 □$30 □$40 □$50 □$60 □$65 □$75
Home health care	□40 visits/$0
Refractive eye exam	□$20 □$25 □$30 □$40 □$50 □$60 □$65 □$75
Optical	□ Not Covered □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. □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. □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)	□Covered □Not covered
Inpatient mental health	□$250 □$500 □$1,000 □Subject to deductible and coinsurance
Inpatient substance use services	□$250 □$500 □$1,000 □Subject to deductible and coinsurance
Inpatient habilitation services	□$250 □$500 □$1,000 □Subject to deductible and coinsurance
Inpatient rehabilitation services	□$250 □$500 □$1,000 □Subject to deductible and coinsurance
Skilled nursing facility	□$0 □Subject to deductible and coinsurance
Dependent coverage (Must select one)	□26 end of month □29 end of month □26 end of year □29 end of year
Domestic partners	□No □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 corporation owns at least fifty percent (50%) of the brother-sister corporations.

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.

Signed at_____

On the _____ day of _____, 20_____

By: _____Title: _____
(print name)

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.

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 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 provider listings, enables you to order ID cards, view an online Explanation of Benefits, access wellness information, and much more.

Translation Services

If English is not your primary language and translation services are needed when calling HIP Customer Service, a representative can help you.

(For EmblemHealth Office Use Only)

	(Initials)
Date Application Issued	
Date Application Received	
Date Application Processed	
Date, Contract and Copy of Application Sent	
Type of Plan	
Group Number	
Benefit Set ID	
Effective Date	
Rep ID	