

Renewal Worksheet (2-50 Eligible Employees)



Please note: Worksheet must be submitted with quote(s) from Empire broker online services to be valid.

Please select one of the following: Plan Year Benefits Calendar Year Benefits

SECTION 1. REASON FOR APPLICATION/CHANGE (FILL IN ONE ONLY)

Group no. 243400	Sub division 1	Sub division 2	Renewal date (MM/DD/YYYY) 12012012
Group name Veratex Inc.			Employer ID no. 132804148

SECTION 2. 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.

No. of Employees

No. of employees at all locations (include owners and partners, exclude COBRA) 5	No. of enrolling employees (include retirees and COBRA) 3	No. of ineligible employees (check reason for ineligibility) 0	Employer contribution to retiree coverage
No. of retirees eligible for coverage 1	No. of net eligible employees 5	<input type="checkbox"/> Temporary <input type="checkbox"/> Union <input type="checkbox"/> Part-time <input type="checkbox"/> Other	
Have you ever employed more than 20 employees? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.

Eligibility Dates (complete both A and B)

A. Initial Enrollment of Group. All employees' and dependents' coverage will be in effect:

On group effective date 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.

B. New Employees (after initial enrollment of group). New employees will be eligible for coverage:

Date of hire First day of the following
30 day(s) following date of hire First of the month following
month(s) following date of hire day(s) following date of hire
month(s) following date of hire

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) _____

SECTION 3. PAYMENT SECTION – Group's contribution, if any.

% Employee only 10%	% Two-party 10%	% Employee + Spouse 10%	% Employee + Child(ren) 10%	% Family 10%
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If your group has multiple locations, do you wish to receive (fill in one): Separate invoices for each location A summary invoice combining all locations.

If you are requesting quarterly billing, please indicate here. Otherwise, group will be billed monthly.

NOTE: In order for this application to be accepted by Empire, your group (i) may NOT subsidize any portion of your covered members' cost-sharing responsibilities, such as copayments and/or member coinsurance (sometimes referred to as a "Gap Plan") and (ii) may NOT fund more than 50% toward the member deductible amount. The offer of either a Gap Plan or funding of more than 50% toward member deductible disqualifies a group from eligibility for Empire small group coverage. By signing below, you are certifying that you do not offer a "Gap Plan" or fund more than 50% of the member deductible amount.

SECTION 4. FULL REPLACEMENT

Is Empire the sole carrier offered by the group?

Yes No

Is this group segmented or offering a dual option? Yes No

If yes, please include a letter of instruction for processing.

SECTION 5. DOMESTIC PARTNER RIDER SELECTION

Same sex only Same and opposite sex No selection

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.

SECTION 6. SIGNATURE OF AUTHORIZED REPRESENTATIVE

Authorized group signature

Print name

Wei Chang

Date (MM/DD/YYYY)

1101042012

VERATEX INC.

160 Madison Avenue New York, NY 10016 212-683-9300 Fax 212-889-5573

08-Oct-2012

Re: Veratex Inc.
Group# 243400

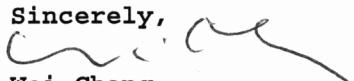
Dear Empire:

Veratex Inc. would like to continue with Empire Small Group coverage, we select Empire PPO Option 1 effective 12/01/2012, and we also like to keep our dental benefit coverage.

We want plan year benefits.

Please call me at 212-683-9300 if you have any question.

Sincerely,


Wei Chang
Administrater



Group Name: VERATEX INC

View Results: Medical Additional Benefits

MEDICAL Additional Selected Benefits		Dental Additional Selected Benefits			
Reimbursement for Gym Membership		100 annual reimbursement per contract; 50 visits required semi-annually. (Reimbursed \$200 every 6 months)			
Employees Under 65		S - \$0.00; E/S - \$0.00; E/C - \$0.00; F - \$0.00			
Medicare Eligible		S - \$0.00; E/S - \$0.00; E/C - \$0.00; F - \$0.00			
Prescription Drug Coverage		11b co-pay/835 co-pay/35% coinsurance; \$50 Deductible; \$350 per prescription max.			
Employees Under 65		S - \$178.29; E/S - \$356.58; E/C - \$320.93; F - \$534.87			
Medicare Eligible		S - \$178.29; E/S - \$356.58; E/C - \$320.93; F - \$534.87			

(1) Network provider delivers care.
(2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider who does not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.)
(3) Out-of-Network (O-O-N) providers - those who do not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-Network providers who do not participate with Empire or with another Blue Cross and Blue Shield Plan may balance bill over Empire's allowed amount.
(4) You are responsible for obtaining preauthorization from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if preauthorization is not obtained. For ambulatory surgery, preauthorization is required for reconstructive surgery, cosmetic transplants and ophthalmological or eye-related procedures. Preauthorization is also required for cosmetic surgery, an excluded benefit except when medically necessary.
(5) You are responsible for obtaining preauthorization from the Behavioral Healthcare Manager for these services. Your provider may call for you but you will be responsible for penalties applied if preauthorization is not obtained.
(6) Out-of-Network reimbursement level is 140% of National Medicare fee schedule.

The coordination rate or other compensation that may be applied by your broker/agent is not charged to premium rate. Small group plans who provide specific additional administrative services may also receive an additional payment from Empire. You can obtain additional information regarding Empire's standard commission rate applied to your product and any applicable reinsurance programs by visiting www.empireblue.com or by contacting your Empire representative.

Net guarantees are based on the above rates as they are based on information you provided. By regulation, these rates are subject to adjustment if Empire files new rates that differ from the rates shown above or if the Superintendent of Insurance approves rates different from the filed rates. In all cases the filed or approved rates apply to the above rates. All groups paying a commercially rated procedure pay the same premium rate.

Dental Single \$ 17.35 monthly rate
Dental Emp/Spouse \$ 54.50 monthly rate
Dental parent/children \$ 54.50 monthly rate



Group Name: VERATEK INC

View Results: Medical Benefits Summary

Medical Benefits Summary		Medical Benefits Summary	
IN-NETWORK		OUT-OF-NETWORK	
Network/Coverage Area		Blue Card/National	
Gated/Not Gated		Not Gated	
Cost-Sharing and Benefit Maximum		Calendar Year	
Calculation period			
Medical Services			
Home/Office Visits	\$45/\$60 Copay	Dependents	
Specialist Visits	\$60 Copay	Dependents	
webVisit	Not Covered	Not Covered	
Ind Ded/Fam Ded	\$1,000/\$2,500	\$2,600/\$5,250	
Coinurance	10%	10%	
Lifetime Maximum	Unlimited	Unlimited	
Out-of-Pocket Maximum	\$3,000/\$7,500	\$7,500/\$15,750	
Hospital Services			
Inpatient	Per Admin / Max. Per Yr Ded+Coins ^a	Per Admin / Max. Per Yr Ded+Coins ^a	
Outpatient	Ded+Coins	Dependents	
ER charges	\$150 (waived if admitted within 24 hrs)	\$150 (waived if admitted within 24 hrs)	
Mental Health			
Inpatient	Up to 30 days / Ded+Coins ^b	Up to 30 days / Ded+Coins ^b	
Outpatient	Up to 20 Visits / \$60 Copay	Up to 20 Visits / Ded+Coins ^b	
Outpatient Office	N/A	N/A	
Outpatient Hospital	N/A	N/A	
Out-Of-Network Reimbursement Level	N/A	100%	
Dependent Children (Covered to the end of the month)	Dependents to Age 26		

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Insurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Prepared by: LORENA TORY

October 4, 2012

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Group Name: VERATEK INC

View Results: Rate Summary

Albion, NY (Covered by State)		Downstate		Other NY (Covered by State)	
Medical Rates		Downstate			
Employee Rates including Selected Riders					
S:	1			\$821.91	
E/S:	0			\$1,642.66	
E/C:	1			\$1,478.52	
F:	0			\$2,463.41	
Medicare Eligible Rates including Selected Riders					
S:	0			\$821.91	
E/S:	1			\$1,642.66	
E/C:	0			\$1,478.52	
F:	0			\$2,463.41	
Medical Total Monthly					
Medical Total Yearly					

MEDICAL monthly rates

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Prepared by: LORENA TERRY

October 4, 2012

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