



TRADITIONPLUS HOSPITAL PROGRAM



PO Box 1407, Church Street Station
New York, NY 10008-1407

TRADITIONPLUS HOSPITAL PROGRAM

PAID-IN-FULL COVERAGE 365 DAYS A YEAR

For people who want real value in a hospital program, Empire BlueCross BlueShield offers the TraditionPLUS Hospital Program.

This program covers you – and your covered dependent’s – hospital-related costs all year round. That’s right, 365 days coverage a year, starting with the very first day. And no qualifying medical questionnaire is required.

Plus, you’ll get important benefits, including:

- Maternity care in birthing centers of hospitals
- Hospital care for newborns
- Outpatient physical therapy
- Radiation therapy
- Care in Skilled Nursing Facilities

Coverage extends to your spouse, and to covered dependents to the end of the calendar year of the 23rd birthday.

PROTECTION YOU CAN RELY ON

At Empire, you will also get peace of mind. When you carry the Empire BlueCross BlueShield identification card, your hospital needs are covered, even if you’re away from home. That’s because the Empire BlueCross BlueShield ID card is accepted without question at over 9,000 hospitals and other facilities nationwide. No other insurance company provides such complete protection across the U.S.

There’s another advantage to Empire BlueCross BlueShield: unlike some other insurance companies, we’re in this business to stay. We’ve proven that by providing health coverage to millions of New Yorkers over the past 65 years. Empire has the knowledge and experience to give you the coverage and options you want, along with the security you need.

REAL VALUE IN A HOSPITAL PROGRAM

365 days of Paid-In-Full Inpatient Hospital Protection:

- Semiprivate rooms and board (paid in full in participating hospitals)
- Full range of hospital services, facilities, equipment and supplies
- Maternity care in birthing centers or hospitals
- Hospital care for newborns, up to 30 days
- Inpatient physical therapy and rehabilitation, up to 30 days
- In-hospital mental and nervous care, up to 30 days

Extensive Outpatient Benefits:

- Emergency care for sudden, serious illness or accidental injury
- Ambulatory surgery (in approved ambulatory surgery centers or hospitals)
- Chemotherapy
- Radiation therapy
- Physical therapy – up to 90 visits per year following surgery or hospitalization
- Kidney dialysis – in a hospital or free-standing facility, or at home

Important Additional Benefits:

- Pre-surgical testing and second surgical opinions
- 365 days at a Skilled Nursing Facility, when pre-approved, for admissions occurring within 10 days of hospital discharge
- 210 days of hospice care
- 200 visits by a certified home health care agency professional – No prior hospitalization may be required, even for away-from-home care

Please note: The benefits described are subject to Empire Managed Benefits provisions and to the terms and limitations of your Empire BlueCross BlueShield contract. For certain services, benefits must be pre-authorized. This contract may limit the number of days, visits or dollar amounts to be reimbursed.

All Empire BlueCross BlueShield contracts require an 11-month waiting period for coverage of pre-existing conditions, unless that period has been met under similar coverage provided by Empire or another insurer.

The TraditionPLUS Hospital program meets the minimum standards for basic hospital insurance as defined by the New York State Insurance Department. This contract does NOT provide basic medical or major medical insurance.

The expected benefits ratio for this contract is 92%. This ratio is the portion of future premium which the Plan expects to return as benefits, when averaged over all individuals with this contract.

EXTRA!

Empire BlueCross TraditionPLUSSM Hospital Program

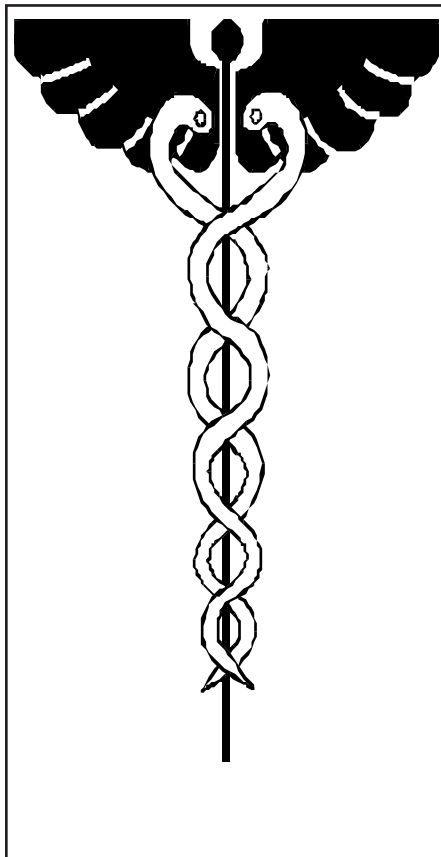
MANY EMPIRE CUSTOMERS ASK:

“WHAT IS THE DIFFERENCE BETWEEN A HOSPITAL SERVICE AND A MEDICAL SERVICE?”

This is an important question since our TraditionPLUSSM Hospital program covers benefits for services rendered and billed by a hospital. We hope the following definitions and examples help explain and clarify some commonly asked questions about our hospital program. Please consult your contract booklet for the specific benefits available to you under this program.

Hospital Services

Hospital services are any services rendered and billed by hospitals or ambulatory surgical centers. The services can either be on an inpatient or outpatient basis and must be for the treatment of an illness or an injury. Hospital services include, but are not limited to, inpatient room and board charges, operating room, delivery room, as well as emergency room charges. They also include radiology and pathology charges for the use of the hospital's x-ray and laboratory equipment. Hospital or facility services do not include any charges billed by or on behalf of independent physicians, even if the physician's services are rendered during a hospital visit.



Medical Services

Medical services are any services rendered and billed by independent physicians, pharmacies, and laboratories, regardless of the place of treatment. Medical services include, but are not limited to, physician's charges for surgery, anesthesiology and the charges for performing, reading, and interpreting x-rays and laboratory tests. It is important to understand that medical services do not include any charges billed by or on behalf of hospitals, ambulatory surgical centers or any type of institutional facilities unless the medical provider is an employee of the hospital and the hospital bills for their services. Services rendered by independent physicians are not included in hospital charges and are not covered under your TraditionPlus Hospital program.

So what does this mean to you?

The TraditionPLUS Hospital program considers services performed in and billed by hospitals or ambulatory surgical centers. It does not provide benefits for medical services of physicians. Prior to your hospital visit, you may wish to inquire if the treating physicians are employed by the hospital or if you will receive separate bills for their services. The following examples address some of the most commonly asked questions and describe how your TraditionPLUS Hospital program benefits apply in each situation.

• EMERGENCY ROOM SERVICES

When emergency room services are rendered at your local participating hospital for the treatment of an accidental injury, your contract will cover the charges billed by the hospital in full. This would include the hospital's charge for the use of x-ray or laboratory equipment, the emergency room fee and any medical services rendered by hospital employees. You may receive separate bills from physicians who are not employed by the hospital. These separate provider bills may include charges from independent emergency room physicians as well as independent radiology and pathology associations or groups. These providers may bill for services such as emergency room treatments (professional services) or interpretations of x-rays and laboratory tests. Although these services are rendered in the hospital, they are considered medical services. Medical Services are not eligible for benefits under your TraditionPLUS Hospital program.

• SURGICAL SERVICES

When surgical services are rendered either on an inpatient or outpatient basis of your local participating hospital, your contract will cover the facility charges in full when all of the Managed Care requirements have been met. (Please consult your contract booklet for the specific Managed Care requirements under the hospital program.) These charges would include the hospital's fee for the operating room, surgical equipment, as well as the fees for the use of any other hospital equipment and any medical services rendered by hospital employees. The separate charges for services rendered by independent physicians, such as the surgeon or the anesthesiologist, would not be covered because they are considered medical services. Medical Services are not eligible for benefits under your TraditionPLUS Hospital program.

• MAMMOGRAPHY SERVICES

When a mammography screening is rendered in the hospital, the hospital charges are covered in full when the services are recommended by a physician for the diagnosis and treatment of an illness, or if the physician recommended the service because the patient is over 35 years of age. The hospital services would include the use of any radiological equipment as well as any medical services rendered by hospital employees. The separate bills from independent radiologist associations or groups for performing or interpreting the test are considered medical services. Medical Services are not covered under your TraditionPLUS Hospital program.

IMPORTANT INSTRUCTIONS FOR COMPLETING YOUR ENROLLMENT APPLICATION

Application Requirements

Each section of your enrollment application must be completed in its entirety before you can be enrolled in the TRADITIONPLUS HOSPITAL PROGRAM. *An incomplete application may result in a delay in coverage.*

Signature of the person who is applying for coverage, and the spouse's signature if also applying for coverage, is required for your application to be considered complete.

Proof of Residence indicating that you are a New York State resident in Empire's 28-county operating area must be submitted with all applications. *The Name and Address on your proof must match the Name and Address listed on your application.* A PO Box is not acceptable on your application or proof; however, it may be listed as a separate mailing address.

Acceptable Proof of Residence Includes: -- *all items must be current and not expired*

- Voter Registration Card
- Driver's License
- Motor Vehicle Non-driver's License
- Motor Vehicle Registration
- New York State Insurance ID Card
- Utility Bill*
- Telephone Bill - cellular phone bills are acceptable*
- Cable Television Bill
- New York State Department of Motor Vehicle Certificate of Title
- Computerized Statement of School or Property Taxes
- Unemployment Check*
- Computerized W-2 Form
- Copy of Current Lease Agreement (signed by tenant and landlord)
- Certificate of Residency*
- Letter from Nursing Home (on company letterhead)

**These items must be dated within the past 90 days.*

Current BlueCross Coverage with Empire or any other Plan that is held by you or any member of your family should be indicated in questions **9-9E**. You should provide us with the name of the Plan, contract holder's name (i.e., the person with the other coverage), and ID number. Also, please specify the type of coverage, including if it is group coverage (e.g., through an employer) or non-group (direct payment) coverage.

continued on next page

INSTRUCTIONS

Please take the time to carefully complete all sections of this application which pertain to you. Incomplete and unsigned applications cannot be processed and may result in a later coverage effective date. DO NOT send payment with this form.

You may submit this application if you do not have comparable coverage available through an employer group or if you are not enrolled on any other health insurance contract. You may use this application to apply for new enrollment, a status change or a transfer of coverage.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Please type or print firmly with blue or black ballpoint pen.

Empire BlueCross BlueShield is licensed to operate in a 28 county area of eastern New York State. You must reside in one of these counties to be eligible to enroll: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester. PO Boxes are not accepted as a valid address.

Section 1-9: Please tell us about yourself and your family.

Section 10: Please check the applicable box.

Section 11: Your choice of contract must be appropriate.

TYPE OF COVERAGE:

- The TraditionPLUSSM Hospital contract is available to persons applying for new enrollment, conversion, contract change or continuation of dependent coverage.

To be Classified as a Family:

- You are married; or
- You are single and have one or more dependent children.

To be Classified as an Individual:

- You are unmarried.
- You are married without dependent children and your spouse is covered by Medicare or another benefit plan that does not provide dependent coverage for you.

NOTE: Same sex spouses must have entered into a marriage legally recognized in the jurisdiction in which it is performed.

DEPENDENT CHILDREN:

- Your child is an eligible dependent if he or she is under 23, unmarried and dependent upon you for support or if he or she is an unmarried child through age 29, without regard to financial dependence, who is not insured by or eligible for coverage under an employer sponsored health benefit plan covering them as an employee or member, whether insured or self-insured, and who lives, works or resides in New York state or the Service Area. Proposed adoptive children and over-age disabled dependent children also qualify. Coverage of each child lasts until December 31 of the calendar year in which the child no longer meets all of these conditions, or the date of marriage, whichever occurs first.

Section 13: Employment status must be completed in full for applicant and spouse.

Section 15: Please be as specific as possible in completing this section. Your response will help us to determine whether a pre-existing condition waiting period or portability of coverage applies to you.

Signature: Your signature, and that of your spouse, must be provided and complete.

NOTE: Please do not send payment with this form. If this application is accepted, we will issue a bill as well as a contract and identification card(s). If issued, the contract(s) will be effective on the date indicated on the identification card(s) if payment of the bill amount is received by Empire BlueCross BlueShield according to the billing notice sent to you.

Use the envelope you received with this application to return your completed application to Empire BlueCross BlueShield. If you have any questions about this program or need assistance in completing this application, please call our Dedicated Service Area at (800) 261-5962. We will be glad to help you.

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DIRECT PAYMENT APPLICATION

FOR OFFICE USE ONLY

1. SOCIAL SECURITY NUMBER	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER			
2. APPLICANT'S LAST NAME		FIRST NAME		MIDDLE INITIAL	
3A. HOME ADDRESS					Apt#
CITY	STATE	ZIP CODE	CARE OF		
3B. MAILING ADDRESS, if different from HOME ADDRESS					Apt. #
4. MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	5. DATE OF BIRTH	6. SINGLE <input type="checkbox"/>	MARRIED <input type="checkbox"/>	SEPARATED <input type="checkbox"/>
			DIVORCED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	
7B. PLACE OF MARRIAGE* CITY					COUNTRY
					STATE
*NOTE: Marriage must have been entered into in a jurisdiction that recognizes its validity.					
8A. Please tell us about you, your spouse and dependent children. If you are applying for coverage for them, you must complete this section. If additional space is required, please provide the information requested below on a separate sheet of paper and attach it to the application.					
	LAST NAME, FIRST NAME, M.I.	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	
SPOUSE		<input type="checkbox"/> M <input type="checkbox"/> F			
CHILD		<input type="checkbox"/> M <input type="checkbox"/> F			
CHILD		<input type="checkbox"/> M <input type="checkbox"/> F			
CHILD		<input type="checkbox"/> M <input type="checkbox"/> F			
CHILD		<input type="checkbox"/> M <input type="checkbox"/> F			
8B. You must be legally domiciled in one of the 28 counties that Empire BlueCross BlueShield is licensed to operate in. You must be able to demonstrate upon request that you can meet at least 1 of the following 2 criteria. Please check the box next to the criteria you meet.					
			<input type="checkbox"/> Hold a valid New York motor vehicle operator's license or non-driver identification card with an address located in the Empire service area;		
			<input type="checkbox"/> Have evidence that you have a permanent dwelling place in the Empire service area (i.e, utility bill, certificate of residency);		
8C. Do you have a child over age 23 who is mentally retarded, physically handicapped or developmentally disabled for whom coverage is being requested under this family contract? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If yes, a separate enrollment form (HAC 506) must be submitted to determine eligibility. <input type="checkbox"/> Please send me a form (HAC 506).					
9. Are you, your spouse or dependent child a member of Empire BlueCross BlueShield or any Blue Cross Blue Shield Plan? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please answer 9A-D and review 9E.					
9A. Name and address of plan:			9B. Contract Holder's Name:		
9C. Identification Number:		Group No.	9D. Type of Coverage (check all that apply) <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Group <input type="checkbox"/> Non-Group <input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Dental		
9E. If any family member listed on this contract is currently enrolled with Empire BlueCross BlueShield, that coverage will be cancelled if permitted under the terms of such other coverage. Membership will be transferred to the coverage requested, unless you indicated otherwise here and the reason is approved. <input type="checkbox"/> DO NOT TRANSFER REASON:					
<hr/> <hr/>					
10. You are submitting this application for:			<input type="checkbox"/> Transfer from another Blue Cross Blue Shield Plan <input type="checkbox"/> Contract Change <input type="checkbox"/> Continuation of Former Dependent Coverage		
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Conversion from prior Empire coverage					
11. Indicate your choice and contract type (Individual or Family). HOSPITAL PROGRAM 365 Day Hospital Coverage					
Contract Type: <input type="checkbox"/> Individual <input type="checkbox"/> Family					

12. PLEASE ANSWER EACH OF THE FOLLOWING FOR YOU AND YOUR SPOUSE (IF ANY).

EMPLOYMENT STATUS	APPLICANT	SPOUSE
12A. SELF-EMPLOYED	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
12B. UNEMPLOYED	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
12C. CURRENTLY EMPLOYED*	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

***IF YES, COMPLETE THE FOLLOWING**

EMPLOYER'S NAME AND ADDRESS		
NUMBER OF EMPLOYEES (if known)		
DATE OF EMPLOYMENT		
FULL TIME		
PART TIME		

13. ARE YOU ELIGIBLE FOR COMPARABLE GROUP COVERAGE THROUGH AN EMPLOYER? YES NO
 HAVE YOU BEEN REFUSED COMPARABLE COVERAGE THROUGH AN EMPLOYER? YES NO
 IF THE ANSWER IS YES TO EITHER QUESTION, PLEASE SPECIFY REASON FOR SUBMISSION OF THIS APPLICATION:

IF YOU OR YOUR DEPENDENT(S) WERE COVERED BY ANOTHER INSURANCE CARRIER WITHIN SIXTY-THREE (63) DAYS OF THE EFFECTIVE DATE OF THIS CONTRACT YOU MAY BE ELIGIBLE FOR CREDIT TOWARD COMPLETION OF ANY APPLICABLE WAITING PERIOD FOR THE TIME ENROLLED WITH THAT CARRIER. TO DETERMINE ELIGIBILITY FOR THIS CREDIT, A LETTER OF PROOF FROM YOUR PRIOR CARRIER OR ANY REASONABLE SUBSTANTIATION OF PRIOR COVERAGE IS REQUESTED. THIS MUST CONTAIN NAME, CONTRACT TYPE, LEVEL OF BENEFITS AND PERIOD OF ENROLLMENT. NO PRE-EXISTING CONDITION EXCLUSION SHALL APPLY TO ANY "ELIGIBLE INDIVIDUAL," AS SUCH TERM IS DEFINED IN §2741(B) OF THE FEDERAL PUBLIC HEALTH SERVICE ACT.

14. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT CHILD(REN) ARE CURRENTLY COVERED OR HAVE BEEN COVERED WITHIN THE PAST 63 DAYS UNDER ANY HEALTH BENEFITS PLAN, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW:

14A. NAME AND ADDRESS OF PLAN _____ _____	14B. NAME OF CONTRACT HOLDER
	14C. IDENTIFICATION NO.
	14D. REASON FOR TERMINATION
14E. Type of Policy (check all that apply) <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Group <input type="checkbox"/> Non-Group <input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Dental	14F. EFFECTIVE DATE MONTH DAY YEAR
	14G. TERMINATION DATE MONTH DAY YEAR

15. Are you, your spouse or any of your dependent child(ren) covered by MEDICARE?
 YES NO If yes, taking information from the red, white and blue Medicare Card, enter the information requested below:

APPLICANT	SPOUSE	CHILD (NAME _____)
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Claim Number and letter		
Hospital Insurance Part A Effective Date		
Medical Insurance Part B Effective Date		

16. If applicant is married and is requesting Individual coverage, please check the appropriate box to indicate reason.

A. Spouse over age 65 years B. Spouse covered by Medicare (over age 65 years under 65 years/disabled)

C. Spouse currently enrolled with Empire BlueCross BlueShield at place of employment and group coverage is not offered to spouse or children of employees.
 Group number _____ Spouse's Identification Number _____

D. Spouse currently enrolled with another health plan at place of employment and group coverage is offered to employees only.
 (A written statement from the group verifying this must be submitted with the application)
 Name of Health Insurance Plan _____

E. Spouse permanently residing outside the United States (a notarized statement must accompany this application).

F. Spouse permanently confined to an institution.
 Name of Institution _____
 Address of Institution _____
 Date of Confinement _____

READ THE FOLLOWING STATEMENT VERY CAREFULLY.

YOUR SIGNATURE(S) ON THIS PAGE INDICATE(S) THAT YOU HAVE READ, UNDERSTAND AND AGREE TO ALL THE PROVISIONS SET FORTH ON THIS APPLICATION AND THAT YOU UNDERSTAND AND AGREE TO THEM. PLEASE SIGN AND DATE.

- A. I hereby request coverage of the type checked. If this request is for a family contract, the names of my spouse and eligible dependent children are listed. I make this application on their behalf as well as my own. If this request is accepted, coverage will be effective only if my payment of the subscription charge is received by Empire BlueCross BlueShield in accordance with the billing notice.
- B. All statements and answers in this application are true and are representations made to induce the issuance of the contract applied for. If accepted, this application will be part of the contract. The contract will become effective on the date specified on the identification card or the identification stub. On that date, my spouse's, or my dependent's existing contracts with Empire BlueCross BlueShield, if any, shall be cancelled except as otherwise noted in item 9E. Any misrepresentation by me of facts which are material to this application may result in rescission of this contract.
- C. There will be an eleven month waiting period for benefits for any physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on our enrollment date for this coverage. Credit for prior creditable coverage will be applied to this waiting period if such coverage was continuous to a date not more than 63 days prior to your enrollment date for this coverage. In the case of previous HMO coverage, any affiliation period prior to that previous coverage becoming effective will also be credited. Upon request, you must provide appropriate documentation of the prior coverage to Empire BlueCross BlueShield.
- D. I authorize any health care provider, payer of health and health related claims, or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim, or services in conjunction with managed care. I authorize Empire to disclose such information to my physician; another payer or self-insurer, and if my coverage is under a group contract held by an employer, association, trust fund, or similar entity, to the group contract holder, or to an Empire designee for purposes of continuity of care and medical management, disease management, managed disability coordination or financial audits. This authorization shall become effective immediately, and shall remain in effect for six years after the termination of coverage, or the last determination or payment by Empire on a claim or service under the coverage. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.
- E. If this coverage is issued, I may make a written request to cancel the contract within 10 days after receipt. Thereafter, 30 days advance written notification to Empire BlueCross BlueShield by the contract holder is required to terminate coverage.

All statements and answers in this application are true, and are representations made to induce the insurance of coverage. Any misrepresentation of material fact may result in cancellation or rescission of coverage.

I attest that I am a resident in one of the 28 counties that Empire BlueCross BlueShield is licensed to operate in and understand that I may be asked to provide evidence to demonstrate my residency per section 8.B.

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 dollars and the stated value of the claim for each such violation. I have read, understand and agree to all the provisions set forth.

Applicant's Signature _____ Date _____

Spouse's Signature _____ Date _____