



HEALTH CARE PLAN OPTIONS

(FOR BUFFALO AND ROCHESTER AREAS)

**FOR MEMBERS
OF
THE WYOMING COUNTY
CHAMBER OF COMMERCE**

2009

APPLYING FOR HEALTH INSURANCE

Wyoming County Chamber of Commerce must receive the following with your insurance applications:

1. Proof of Business / Employment.

2. If you are a business or corporation, we will need a copy of your most current Business License with your Employer Identification Number (EIN), copy of your DBA or Corporate papers.
3. If an *employee* is applying, please submit proof of employment (i.e., copy of most current NYS-45, listing company name and list of employees. For new employee not yet on NYS-45, a payroll journal showing a minimum 20 hours per week worked.

Each health insurance provider may require further documentation.

4. **Insurance Application.** Be sure to enclose your insurance application and a check for the quarterly or monthly amount. Checks should be payable to **Wyoming County Chamber of Commerce** and **MAILED** to the Billing Administrator:

EBS - RMSCO, Inc.
Attn: Julie Lalonde or Sue Beiter
25 Northpointe Parkway, Suite F
Amherst, New York 14228

5. **Agreement.** If you are enrolling for the first time as a member electing health care coverage through the Wyoming County Chamber please sign and return the Agreement to us.
6. **Company Information.** Please complete the information requested below, sign, date and return with the above mentioned items to EBS-RMSCO, Inc., at the address above.

Employer Name: _____

Billing Address: _____

Billing Contact: _____ **Phone No.:** _____

Billing Option (please check one):

Monthly - \$ 5.00 per applicant/subscriber plus \$5.00 monthly billing fee

Quarterly - \$15.00 per applicant/subscriber

Authorized Signature: _____ **Date:** _____

Please Print Name: _____ **Title:** _____

Wyoming County Chamber of Commerce

Health Insurance - Member Agreement

I understand that I must be a member in good standing of the Wyoming County Chamber of Commerce to acquire and continue my health insurance coverage at group rates.

I understand that my insurance bill must be paid by the due date stated on the invoice and that failure to do so will result in immediate cancellation of my coverage.

I also understand that, once cancelled, my insurance may be reinstated within ten (10) days of the due date by adding a \$50.00 reinstatement processing fee to my quarterly premium. Reinstatement may be made "one time" only.

I understand that personal/business checks and bank checks are the only acceptable forms of payment of my insurance premium and that there will be a minimum \$45.00 charge for any checks returned for insufficient funds.

I understand that the Wyoming County Chamber of Commerce its officers, directors, employees or third party administrators make no representations about the nature or extent of the health care coverage that I select or purchase and that any information that they provide is for the purposes of illustration only and is superseded by the actual agreement which I enter into with the health insurance provider.

In consideration of the Wyoming County Chamber of Commerce processing and submitting my application and payments to the health insurance provider, I agree I will not hold the Wyoming County Chamber of Commerce, its officers, directors, employees, consultants or third party administrator liable for damages resulting from cancellation of coverage, lapse of coverage, absence of coverage or failure to cancel coverage whether by reason of intentional or inadvertent acts or omissions of the Wyoming County Chamber of Commerce or intentional or inadvertent acts or omissions of the health insurance provider.

By signing below, I am stating that I agree to all of the above stated terms.

Signature: _____ Date: _____

Name: _____

Title: _____

Company: _____ Phone: _____

Wyoming County Chamber of Commerce Group Insurance Program Highlights

The descriptions provided are intended to serve as a guide to assist you in evaluating health insurance plans available through the Wyoming County Chamber of Commerce. The Program Highlights describes in general the main features of the insurance programs available through the Wyoming County Chamber of Commerce. For complete terms, conditions, limitations and exclusions refer to your subscriber agreement or contract.

Program Fees & Procedures

- ◆ \$15.00 Quarterly billing fee for each subscriber (not prorated for mid-quarter enrollments).
- ◆ \$5.00 Fee for subscribers electing to pay monthly (in **addition** to billing fee stated above).
- ◆ \$50.00 reinstatement fee for contracts cancelled for late payment or non-payment of premiums.
- ◆ Premiums for health insurance are billed quarterly or monthly in advance of the coverage period.
- ◆ Due date for premium remittance are clearly indicated on all invoices (generally the 15th of the month).

Membership & Participation Requirements

- ◆ **Member business must enroll within 30 days of becoming a Chamber member.** New employees of an existing member business must enroll within 15 days of the date of hire (coverage is 1st of month following 30 days of hire). Those who choose not to enroll when first eligible can apply for coverage at the next open enrollment period, **which is during the month of December, with an effective date of coverage of January 1st** of each year.
- ◆ Member businesses must submit proof of business (i.e., copy of most recent Business License with employer tax ID, DBA or corporate papers) and proof of employee eligibility (i.e., copy of most current NYS-45 or payroll journal listing company name for new employees not yet reported on the NYS-45).
- ◆ Member business must complete the Group Registration forms as required by the respective insurance carriers.
- ◆ Participants must be employed by a business member in good standing with the Wyoming County Chamber of Commerce and work a minimum of 20 hours per week.
- ◆ For each participant, member business must submit proof of employment (i.e. copy of most current NYS-45 or journal listing company name for new employees not yet reported on the NYS-45) and/or other forms required by the specific carrier for the plan selected.
- ◆ The Billing Plan Administrator -EBS-RMSCO, Inc.- must receive applications, payments and proof of eligibility **45 days prior to the coverage effective date.**
- ◆ For **Sole Proprietors** coverage begins on the 1st of the month following 60 days of membership.

Completed applications and enrollment documents should be mailed to:

**Sue Beiter or Julie Lalonde
EBS-RMSCO, Inc.
25 Northpointe Parkway, Suite F
Amherst, New York 14228
(716) 564 – 2747
or
Toll Free (888) 831–9120 Ext: 7**

**Important Reminder to Member Businesses Offering Employer Sponsored
Group Health Insurance Plans to Employees through
Wyoming County Chamber of Commerce**

Medicare Part D – Employer Responsibilities

The Wyoming County Chamber of Commerce does not provide guidance in compliance with Federal, State, or local laws and regulations. The purpose of this notice is to provide general information that may assist you in determining what your responsibilities may be.

BACKGROUND

Last year we informed you of the “Creditable Coverage” notification requirements for Medicare eligible employees required by the Centers for Medicare and Medicaid Services (CMS).

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a prescription drug program to Medicare. The related Federal Regulations established certain requirements for employers that provide prescription drug coverage to Medicare Part D eligible beneficiaries.

Employers, whose plans provide prescription drug coverage to Medicare eligible active employees and their dependents, as well as Medicare eligible retirees and dependents, are required to communicate whether or not the prescription coverage is creditable to both the Medicare eligible beneficiaries **and** to the Centers for Medicare and Medicaid Services (CMS). **This notification is required at certain times throughout the year.**

COMPLIANCE INFORMATION SOURCE: CMS ONLINE

Complete information on the Medicare Part D Prescription Drug Program and meeting the employer requirements is available from CMS online at www.cms.hhs.gov/CreditableCoverage

CREDITABLE COVERAGE DETERMINATION

The carrier(s) that provides your Employer Sponsored Group Health Plan(s) can inform you whether or not the prescription drug coverage provided by the plan(s) is Creditable.

If you have questions on the different coverage options available through a specific plan or have questions on comparisons of plans, please contact Bob Papelian at Benefits Management Group at 716-849-9999 ext. 305.

Once you decide on a plan that you would like to participate in, please contact Julie Lalonde or Sue Beiter at EBS-RMSCO, Inc. at 888-831-9120 ext. 7 for an application.