UnitedHealthcare®
Oxford

Freedom Plan® Metro℠
Liberty Plan℠ Metro
Freedom Plan® Metro Access℠
Liberty Plan℠ Metro Access
Oxford Exclusive Plan℠ Metro
Oxford Ease℠
Freedom Plan® Direct℠
Liberty Plan℠ Direct
Oxford MyPlan℠
Oxford® HSA Exclusive℠
Oxford® HSA Direct℠
Primary Advantage

New York Small Group (2-50) Application – OHI

Oxford Health Insurance Inc. ▪ www.oxfordhealth.com
Mailing Address: Group Enrollment Department, 14 Central Park Drive, Hooksett, NH 03106

I. GENERAL INFORMATION

1. **Full Legal Name of Group:**

2. **Primary Address of Group:**
(Street Address
City, State, ZIP Code)
No P.O. Box

3. **Plan Administrator/Contact:**

a. Name

b. Title

c. Address
(If different from primary)
City, State, ZIP code

d. Phone Number Ext.

e. Fax Number

f. Email Address

g. Add'l Contact & Number

4. **Name and title of person to receive billing statements:**

a. Name

b. Title

c. Address
(If different from primary)
City, State, ZIP code

d. Phone Number Ext.

e. Fax Number

5. **Full legal name of each subsidiary and/or affiliated company whose employees are to be covered (if applicable):**

6. **Nature of Business:**

7. **SIC Code:**

8. **Tax Identification Number:**

II. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate of Coverage. To be eligible for small group coverage, you must be located in a county where we offer this Oxford product and have at least 2 but not more than 50 eligible employees.

1. Effective date: We request that this coverage be effective _____.
2. Anniversary date: The anniversary date is the first day of the calendar month that is closest to the effective date.
3. Open enrollment period: The open enrollment period is the month prior to your anniversary date. The open enrollment effective date is the first of the month following the period.
4. How many total employees does this group have? _____

   Total employees means the average number of employees, including seasonal and/or part time employees, during the prior calendar year.
5. How many eligible employees does this group have? _____

   Eligible employees: Active permanent employees of the employer and of all subsidiaries or affiliates of a corporate employer who work **20 or more** hours per week and are eligible for health benefits through the employer's group health plan. Eligible employees do not include:

   – any person who performs services for the company who is reported on an IRS 1099 form (such a person is not an employee and is not eligible for coverage) or

   – any former employee who is covered through retiree benefits, COBRA or state continuation.

   An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours and occupational duties. Employees who work less than 20 hours per week are not eligible employees and may not enroll in any Oxford products. If coverage is limited to specific class(es) of employees, the classes must be specified in response to question 13 below.

   If the employer does not offer group health coverage to all eligible employees, eligible employees should include (1) the number of eligible employees who work in the state of New York and (2) if the employer offers Oxford coverage to out-of-state employees, the number of out-of-state eligible employees.
6. Total number of employees being offered coverage through this product: _____

   Of the eligible employees who work 20 or more hours per week, please list all employees who will be offered coverage under this policy. If coverage is limited to specific class(es) of employees, the classes must be specified in response to question13 below.

   Groups seeking to purchase insurance, rather than HMO coverage, also must meet the minimum participation requirements for coverage. A minimum of 51% of all eligible employees after valid waivers must be enrolled, and Oxford Health Insurance Inc. must be the sole carrier for all eligible employees who work in New York and are eligible employees and offered coverage by the group.
7. If the employer offers retiree coverage, how many eligible retired former employees does this group have? _____

   Integration with Medicare benefits: Health benefits covered by Medicare Part A and B are carved out for retired employees aged 65 or over and their dependents aged 65 or over, if the group offers retiree coverage.
8. Total number of employees and former employees enrolling: _____

   Enrolling means the total number of eligible employees, COBRA or state continuation enrollees, and retired employees (if applicable) accepting coverage with any Oxford product.

   a. of those former employees enrolling, how many are retired? _____

   b. of those former employees enrolling, how many are enrolling through COBRA or state continuation? ____
9. Total number of employees waiving coverage for the following reasons:

   a. A spouse's health benefit plan: _____

   b. Medicare: _____

   c. Medicaid: _____

   d. Veteran's coverage: _____

   e. All other waivers: _____
10. Total number of valid waivers (a - d): _____
11. Is the Employer offering other group or HMO coverage to employees who are eligible for coverage in an Oxford product? __ YES __ NO

    Please list other current or past group health or HMO coverage offered by Employer in the last three years:

Type of coverage	Name of carrier	Effective date	If terminated, date terminated

II. ADMINISTRATIVE INFORMATION (CONTINUED)

12. Is your group subject to COBRA (20 or more total employees during at least 50% of the working days in the previous calendar year)?
___ YES __ NO

13. Eligible employee class(es), Waiting period and Termination:

If coverage is being limited to particular class(es) of employees, please specify class definition(s) below. An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours, and occupational duties. Although an Employer may establish a class of employees who work less than 20 hours per week, Oxford products are not available to employees who work less than 20 hours per week. Oxford must be the sole carrier for all eligible employees who work in New York state as well as any other eligible employees located outside the state of New York who are eligible for coverage under a New York group health benefits plan.

If classes and waiting periods are not specified below, all eligible employees who work 20 or more hours per week will be eligible for group health benefits under an Oxford policy without a waiting period.

Eligibility and Termination: The employee will become eligible on the latter of the effective date of this plan or the date selected below (check appropriate date).

CLASS I

Definition of Class I _____

_____

i) **Eligibility/Termination**

❑ Date on which the employee completes _____ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

ii) **Eligibility/Termination**

❑ On the first day of the calendar month coinciding with or next following the date on which the employee completes _____days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

iii) **Waiting Period for Rehires**

Waiting Period waived for Rehires? ❒ Yes ❒ No
If yes, waived if rehired within _____ months.

CLASS II

Definition of Class II _____

_____

i) **Eligibility/Termination**

❑ Date on which the employee completes _____ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

ii) **Eligibility/Termination**

❑ On the first day of the calendar month coinciding with or next following the date on which the employee completes _____days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

iii) **Waiting Period for Rehires**

Waiting Period waived for Rehires? ❒ Yes ❒ No
If yes, waived if rehired within _____ months.

III. PRODUCT AND PLAN DESIGNS

A. Oxford Plan Metro (Referrals are required for these plan designs.)

Instructions: Please select a plan option and check off any variable items as provided below.

Please Select Network: ❑ Freedom ❑ Liberty

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3
Copayment: **a. PCP** **b. Specialist**	 $15 per visit $25 per visit	 $25 per visit $40 per visit	 $50 per visit $75 per visit
Inpatient/Outpatient Facility Copayment	$250 per day up to five days Inpatient ($1,250 max. copayment per year) / $250 Outpatient	$500 per day up to five days Inpatient ($2,500 max. copayment per year) / $500 Outpatient	$750 per day up to five days Inpatient ($3,750 max. copayment per year) / $500 Outpatient
Emergency Room Copayment	$200	$200	$200
Out-of-Network Deductible	$2,000 Single $6,000 Family	$2,000 Single $6,000 Family	$3,000 Single $9,000 Family
Out-of-Network Coinsurance	70% to $10,000	70% to $10,000	70% to $20,000
Out-of-Network Reimbursement	140% of Medicare rate[1]	140% of Medicare rate[1]	140% of Medicare rate[1]

Deductibles and out-of-pocket accumulators are on a calendar year basis.

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium ❑ Other:_____
Subject to Home Office Approval

❑ Mandated Offering – Dependent Age Extension to 29
❑ Domestic Partner
❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Unlimited Mental Health ***

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
❑ Option 1	$10 copayment	$30 copayment	$60 copayment	2.5x copayment	❑$100 ❑$250 ❑$500
❑ Option 2	$15 copayment	50%	50%	2.5x copayment or 50%	❑$50 ❑$100 ❑$250 ❑$500
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

**Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives: ❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

[1] When a Medicare rate is not available, reimbursement is based upon ceratin gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

B. Freedom Plan Metro Access and Liberty Plan Metro Access (Non-gated – No referrals required)

Instructions: Please select a network, plan option and any additional benefit options as provided below.

Please Select Network: ❑ Freedom ❑ Liberty

Options	❑ Metro Plan Access Option 1	❑ Metro Plan Access Option 2	❑ Metro Plan Access Option 3
Office visit Copayment	$20 PCP/$30 specialist	$30 PCP/$50 specialist	$50 PCP/$75 specialist
Hospital Copayment	$500 per admission	$500 per admission	$750 per admission
Outpatient/Hospital Ambulatory Surgery	$250 copayment	$500 copayment	$500 copayment
Out-of-Network Deductible – Single/Family	$2,000/$6,000	$3,000/$9,000	$3,000/$9,000
Out-of-Network Coinsurance – Single/Family	70% to $10,000/$30,000	70% to $10,000/$30,000	70% to $20,000/$60,000
Out-of-Network Reimbursement	140% of Medicare rate[1]	140% of Medicare rate[1]	140% of Medicare rate[1]

Deductibles and out-of-pocket accumulators are on a calendar year basis.

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium
❑ Mandated Offering – Dependent Age Extension to 29
❑ Domestic Partner
❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Unlimited Mental Health***
❑ Other:_____
Subject to Home Office Approval

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
❑ Option 1	$10 copayment	$30 copayment	$60 copayment	2.5x copayment	❑$100 ❑$250 ❑$500
❑ Option 2	$15 copayment	50%	50%	2.5x copayment or 50%	❑$50 ❑$100 ❑$250 ❑$500
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

**Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives: ❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

C. Oxford Exclusive Plan Metro (Non-gated – No referrals required)

Instructions: Please select a plan option and check off any variable items as provided below.

Please Select Network: ❑ Freedom ❑ Liberty

In-Network Only

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6
Copayment: **a. PCP** **b. Specialist**	 $15 per visit $30 per visit	 $25 per visit $50 per visit	 $15 per visit $30 per visit	 $25 per visit $50 per visit	 $20 per visit $40 per visit	 $50 per visit $75 per visit
Single Deductible	none	none	$1,000	$2,000	N/A	$2,500
Family Deductible	none	none	$2,500	$5,000	N/A	$6,250
Coinsurance	none	none	80% to $10,000/$25,000	90% to $10,000/$25,000	N/A	80% to $20,000/$50,000
Outpatient Facility Copayment	$150 per incident	$300 per incident	Deductible & Coinsurance	Deductible & Coinsurance	$200 per incident	Deductible & Coinsurance
Inpatient Facility Copayment	$150 per day to five days maximum per year	$300 per day to five days maximum per year	Deductible & Coinsurance	Deductible & Coinsurance	$200 per day to five days maximum per year	Deductible & Coinsurance
Emergency Room	$200	$200	$200	$200	$200	$200

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year ❑ contract year basis (plans 3, 4 and 6 only).

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium
❑ Mandated Offering Dependent Age Extension to 29
❑ Domestic Partner
❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Unlimited Mental Health***
❑ Other:_____
Subject to Home Office Approval

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
❑ Option 1	$10 copayment	$30 copayment	$60 copayment	2.5x copayment	❑$100 ❑$250 ❑$500
❑ Option 2	$15 copayment	50%	50%	2.5x copayment or 50%	❑$50 ❑$100
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

**Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives: ❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

D. Oxford Ease (Non-gated – No referrals required)

Please Select Network: ❑ Freedom ❑ Liberty

In-Network Only

Option	❑ Plan 1
Copayment: **a. PCP** **b. Specialist**	 $50 per visit $50 per visit
Single Deductible	N/A
Family Deductible	N/A
Coinsurance	N/A
Outpatient Facility Copayment	$500 per incident
Inpatient Facility Copayment	$500 per day, up to a maximum of $2,500 per calendar year
Emergency Room	$200

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium
❑ Mandated Offering – Dependent Age Extension to 29
❑ Domestic Partner
❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Unlimited Mental Health***
❑ Other:_____
Subject to Home Office Approval

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
❑ Option 1	$15 copayment	$35 copayment	$75 copayment	2.5x copayment	❑$50 ❑$100
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

**Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives: ❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

E. Freedom Plan Direct and Liberty Plan Direct (No referrals are required for these plan designs.)

Please Select Network: ❑ Freedom ❑ Liberty

In-Network/Out-of-Network

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4
Copayment	$25 PCP / $40 Specialist	$25 PCP / $40 Specialist	$30 PCP / $50 Specialist	$50 PCP / $75 Specialist
Single Deductible	$500/$1,000	$1,000/$2,000	$2,000/$2,000	$2,500/$6,000
Family Deductible	$1,250/$2,500	$2,500/$5,000	$5,000/$5,000	$6,250/$15,000
Coinsurance	80%/60%	80%/60%	80%/60%	80%/60%
Out-of-Network Reimbursement	140% of Medicare rate[1]	140% of Medicare rate[1]	140% of Medicare rate[1]	140% of Medicare rate[1]
Single Maximum Out-of-Pocket	$2,500/$5,000	$3,000/$6,000	$4,000/$6,000	$6,500/$18,000
Family Maximum Out-of-Pocket	$6,250/$12,500	$7,500/$15,000	$10,000/$15,000	$16,250/$45,000

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year ❑ contract year basis.

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium
❑ Mandatory Offering – Dependent Age Extension to 29
❑ Domestic Partner
❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Unlimited Mental Health***
❑ Other:_____
Subject to Home Office Approval

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
❑ Option 1	$10 copayment	$30 copayment	$60 copayment	2.5x copayment	❑ $100 ❑ $250 ❑ $500
❑ Option 2	$15 copayment	50%	50%	2.5x copayment or 50%	❑ $50 ❑ $100 ❑ $150 ❑ $250
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

**Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives: ❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

F. Oxford MyPlan (No referrals are required for these plan designs.)

Please note: Groups enrolling in the Oxford MyPlan must also fill out an Oxford MyPlan Health Reserve Account Group Application Form (#6740).

Please Select Network: ❑ Freedom ❑ Liberty

In-Network/Out-of-Network

Please select a plan type:

Options	❑ Plan 1	❑ Plan 2
Copayment	N/A	N/A
Single Deductible	$1,000/$2,000	$2,000/$2,000
Family Deductible	$2,500/$5,000	$5,000/$5,000
Coinsurance	80%/60%	90%/70%
Out-of-Network Reimbursement	140% of Medicare rate[1]	140% of Medicare rate[1]
Single Maximum Out-of-Pocket	$3,000/$6,000	$3,000/$5,000
Family Maximum Out-of-Pocket	$7,500/$15,000	$7,500/$12,500

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year ❑ contract year basis.

Please select optional prescription drug coverage:

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium
❑ Mandated Offering – Dependent Age Extension to 29
❑ Domestic Partner
❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Unlimited Mental Health***

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
❑ Option 1	$10 copayment	$30 copayment	$60 copayment	2.5x copayment	$100 (Required)
❑ Option 2	$15 copayment	50%	50%	2.5x copayment or 50%	$50 (Required)
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

** Deductible applies to Tier 2 and Tier 3 drugs.

Contraceptives: ❑ Yes (Standard) ❑ No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

G. Oxford HSA Exclusive (No referrals are required for these plan designs.)

Please note: Groups enrolling in the Oxford HSA Exclusive must also fill out an Oxford HSA Notification Form (#7423).

Please Select Network: ❑ Freedom ❑ Liberty

In-Network Only

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6	❑ Plan 7
In-Network Cost Share:							
a. PCP	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $20	Deductible then $25	Deductible then $30
b. Specialist	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $40	Deductible then $50	Deductible then $50
Single Deductible**	$1,250	$2,000	$2,850	$5,000	$1,250	$2,000	$2,850
Family Deductible**	$2,500	$4,000	$5,700	$10,000	$2,500	$4,000	$5,700
Coinsurance	100%	100%	100%	100%	100%	100%	100%
In-Network Outpatient Facility Copayment	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $200 Copayment	Deductible then $250 Copayment	Deductible then $300 Copayment
In-Network Inpatient Facility Copayment	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $200 per day to $1,000 max. per year	Deductible then $250 per day to $1,250 max. per year	Deductible then $300 per day to $1,500 max. per year
Emergency Room	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $200	Deductible then $200	Deductible then $200
Single Maximum Out-of-Pocket	$5,000	$5,000	$5,000	$5,950	$5,000	$5,500	$6,050
Family Maximum Out-of-Pocket	$10,000	$10,000	$10,000	$11,900	$10,000	$11,000	$12,100

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year ❑ contract year basis.

Please select prescription drug coverage (Required):**

Options	Tier 1	Tier 2	Tier 3	Mail-Order
❑ Option 1	$10 copayment	$30 copayment	$60 copayment	2.5x copayment
❑ Option 2	$15 copayment	50%	50%	2.5x copayment or 50%
❑ Option 3 (available with medical plans 5, 6 & 7 only)	$15 copayment	$35 copayment	$75 copayment	2.5x copayment

**NOTE: All in-network medical and pharmacy services are subject to the in-network deductible. Once the deductible has been satisfied, the applicable medical coinsurance or copayment, and prescription drug copayment will apply based on the option selected at plan inception. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket have been met. Out-of-network benefits are accumulated separately.

Contraceptives: ❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

Additional Benefit Options: ❑ Vision
❑ Dental Enhanced
❑ Dental Premium
❑ Mandated Offering – Dependent Age Extension to 29
❑ Domestic Partner
❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Unlimited Mental Health***
❑ Other:_____
Subject to Home Office Approval

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

H. Oxford HSA Direct (No referrals are required for these plan designs.)

Please note: Groups enrolling in the Oxford HSA Direct must also fill out an Oxford HSA Notification Form (#7423).

Please Select Network: ❑ Freedom ❑ Liberty

In-Network/Out-of-Network

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6
In-Network Cost Share:						
a. PCP	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
b. Specialist	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Single Deductible**	$1,250/$2,000	$2,000/$2,000	$2,850/$2,850	$1,250/$2,000	$2,000/$2,000	$2,850/$2,850
Family Deductible**	$2,500/$4,000	$4,000/$4,000	$5,700/$5,700	$2,500/$4,000	$4,000/$4,000	$5,700/$5,700
Coinsurance	80%/60%	90%/70%	90%/70%	100%/70%	100%/70%	100%/70%
In-Network Outpatient Facility Copayment	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
In-Network Inpatient Facility Copayment	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Single Maximum Out-of-Pocket	$3,250/$6,000	$3,000/$5,000	$3,850/$5,850	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
Family Maximum Out-of-Pocket	$6,500/$12,000	$6,000/$10,000	$7,700/$11,700	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000

Options	❑ Plan 7	❑ Plan 8	❑ Plan 9
In-Network Cost Share:			
a. PCP	Deductible then $20	Deductible then $25	Deductible then $30
b. Specialist	Deductible then $40	Deductible then $50	Deductible then $50
Single Deductible**	$1,250/$2,500	$2,000/$4,000	$2,850/$5,700
Family Deductible**	$2,500/$5,000	$4,000/$8,000	$5,700/$11,400
Coinsurance	100%/70%	100%/70%	100%/70%
In-Network Outpatient Facility Copayment	Deductible then $200	Deductible then $250	Deductible then $300
In-Network Inpatient Facility Copayment	Deductible then $200 per day to $1,000 max. per year	Deductible then $250 per day to $1,250 max. per year	Deductible then $300 per day to $1,500 max. per year
Emergency Room	Deductible then $200	Deductible then $200	Deductible then $200
Single Maximum Out-of-Pocket	$5,000/$10,000	$5,500/$10,000	$6,050/$10,000
Family Maximum Out-of-Pocket	$10,000/$20,000	$11,000/$20,000	$12,100/$20,000

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year ❑ contract year basis.

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Additional Benefit Options: ❑ Vision
❑ Dental Enhanced
❑ Dental Premium
❑ Mandated Offering – Dependent Age Extension to 29
❑ Domestic Partner
❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Unlimited Mental Health***
❑ Other:_____
Subject to Home Office Approval

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Please select optional prescription drug coverage (Required):**

Options	Tier 1	Tier 2	Tier 3	Mail-Order
❑ Option 1	$10 copayment	$30 copayment	$60 copayment	2.5x copayment
❑ Option 2	$15 copayment	50%	50%	2.5x copayment or 50%
❑ Option 3 (available with medical plans 7, 8 & 9 only)	$15 copayment	$35 copayment	$75 copayment	2.5x copayment

Contraceptives: ❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)

**NOTE: All in-network medical and pharmacy services are subject to the in-network deductible. Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copayment will apply based on the option selected at plan inception. Out-of-network benefits are accumulated separately. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket have been met.

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

I. Oxford – Primary Advantage (Non-gated – No referrals required)

Note: The below is not an all inclusive list of plan benefits.

Option	❑ Plan 1
Cost Share: **a. PCP** **b. Specialist**	 $25 copayment Deductible then $50 copayment
Single Deductible	$1,500
Family Deductible	$3,750
Coinsurance	N/A
Outpatient Facility Copayment	Deductible then $150 copayment
Inpatient Facility Copayment	Deductible then $250 copayment up to 5 days per admission
Emergency Room	Deductible then $250 copayment
Pharmacy**	$15/Deductible then 50% up to $250 per prescription

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year ❑ contract year basis.

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium
❑ Mandated Offering - Dependent Age Extension to 29
❑ Domestic Partner
❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Unlimited Mental Health***
❑ Other:_____
Subject to Home Office Approval

**NOTE: All in-network medical and pharmacy services are subject to the in-network deductible. Once the deductible has been satisfied, the applicable medical coinsurance or copayment, and prescription drug copayment will apply based on the option selected at plan inception. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket have been met. Out-of-network benefits are accumulated separately.

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year

Contraceptives: ❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees? ❑ Yes ❑ No

IV. RATE INFORMATION

Monthly Rates: All new groups are subject to the four-tier rate structure indicated below. Rates must be included in the spaces below for application processing. Please note: All four categories must be completed.

Single	Couple	Parent/Children	Family
$	$	$	$

V. BROKER/AGENT INFORMATION

	Broker	Co-Broker	General Agent
1. Name of Payee:			
2. Payee's Oxford Broker Code (Required):			
3. Payee's Social Security # or Federal Tax ID # :			
4. Name of Writing Agent (Required if Payee is a company):			
5. Writing Agent's Oxford Broker Code (Required if Payee is a company):			
6. Commission Split % :			
7. Sales Representative:			
Comments:			

VI. CONSENT

AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford to accept the Broker or General Agent named above as an authorized Benefits Administrator for purposes of processing any enrollment transactions for my company's Oxford policy (including, but not limited to, Member enrollments, Member terminations, Member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations).

This authorization shall be effective immediately and shall (check one only):

_____ Remain in place until it is expressly revoked by me in writing.

_____ Remain in place until _____.
DATE

Further, I agree that my company will be bound by the actions performed by the herein-named Broker or General Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about any Member. acknowledge that I must notify Oxford in writing to void this agreement in the event of a change in my company's Broker of Record.

VII. COBRA & EXTENSION OF BENEFITS DATA

1. Do you have any individuals currently on COBRA continuation? ❒ Yes ❒ No
   If yes, identify the number of individuals_____.
2. Are there any dependents of employees who are currently disabled or in the hospital? ❒ Yes ❒ No

   What is the length of the prior carrier's extension of benefits period for disabled employees or dependents? _____

VIII. APPLICANT AGREEMENT

This Application and the premium rates proposed by Oxford are subject to approval, in writing, by Oxford and may change due to differences in actual versus proposed enrollment, selection of benefits, changes in census data or underwriting criteria, or any other changes in underwriting as determined by Oxford. We reserve the right to modify rates in the event a plan design must be modified as a result of any change, modification or clarification in law. We also retain the right to correct typographical errors or discrepancies prior to the effective date of coverage, and take other actions (for example due to a misrepresentation of a material fact) as permitted by applicable state law.

I, the undersigned, on behalf of the above named company (the "Applicant") am applying for small group health coverage and understand that the information provided will be used to determine eligibility for coverage, premium rates and for other purposes. I confirm that all information gathered herein is accurately represented, complete, and that the Applicant is not aware of any information that was not disclosed.

The Applicant confirms that we employ no more than 50 eligible active permanent employees and no fewer than 2 eligible active permanent employees. The Applicant understands that 1099-compensated individuals are not eligible for group coverage with Oxford.

The Applicant understands that this Application may be chosen for an audit to confirm the information provided. Audits may be conducted before or after enrollment. If documents reviewed or submitted during an audit show that the information provided on an application was false or that the group does not meet underwriting requirements, the group will not be enrolled (audit completed prior to enrollment) or will be terminated (audit completed post enrollment).

The Applicant understands that other audits may be conducted while the Group Policy and Group Enrollment Agreement is in effect and agrees that all documents or other information that may impact coverage or premiums will be available for inspection.

The Applicant hereby acknowledges and understands that this application does not constitute any obligation by Oxford to offer coverage and no insurance will be effective unless and until the application is formally accepted, in writing, by the Oxford entity underwriting the coverage. The Applicant hereby confirms that it will not cancel any current health coverage it may currently have in anticipation that this application will be accepted by Oxford. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of completion and/or submission of this Application. Further, I hereby certify on behalf of the Applicant that the Applicant has not had a group health policy or health maintenance organization contract terminated within the past 12 months due to failure to pay premiums.

If coverage is formally accepted, the Applicant understands that this application and any subsequent addenda (including, but not limited to, any member application forms and renewal certifications) will become part of the Group Policy and Group Enrollment Agreement issued by Oxford. Any material misrepresentation within the application or the addenda (whether intentional or unintentional) may subject the group to termination or other action permitted by law. By signing below, the Applicant agrees to be bound by the terms and conditions of the Group Policy and Group Enrollment Agreement. The plan documents (including, but not limited to, the application, policy certificate(s) and riders) will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan, and will govern in the event they conflict with any benefits comparison, summary of coverage or other description of the plan.

The Applicant agrees to offer coverage to all eligible employees and that only those employees or former employees and their spouses or dependants who are eligible for coverage will be enrolled.

By signing below, you are signing the group application on behalf of the group applying for coverage and stating that (1) I am the Applicant or the agent for the Applicant and am authorized to sign this Group Application and (2) the Applicant will be legally bound by the terms and conditions of the application, this authorization and the plan documents.

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 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 $5,000 dollars and the stated value of the claim for each violation.

Dated at:_____this_____day of_____ 20_____.

_____

Full legal name of firm:_____

X_____

Signature of Authorized Company Representative | Title

_____

Witness | Duly Licensed Resident Agent/Broker