

New York Member Enrollment Form – OHI

MAILING ADDRESS: P. O. Box 7085, Bridgeport CT 06601 • 1-800-444-6222 • www.oxfordhealth.com



THANK YOU FOR CHOOSING AN OXFORD PRODUCT
FOR YOU AND YOUR FAMILY.

IMPORTANT:

PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.

IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE,
ALL FIELDS MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

- ✎ Use only blue or black ballpoint pen
- ✎ Enter all dates using the MM/DD/YYYY format
- ✎ Employer and employee signatures are required
- ✎ List any coordinating coverage (coverage in addition to this coverage)
- ✎ List any coverage you had prior to this coverage
- ✎ Attach disability paperwork, if applicable
- ✎ Check “full-time student” in the child column if the child is between the ages of 19-23 and a full-time student at an accredited institution
- ✎ Check “young adult” in the child column if the child is under the age of 30, eligible, and enrolling onto the young adult option. The young adult will also need to list their qualifying event, address and signature.
- ✎ Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation

IF YOU HAVE ANY QUESTIONS,
PLEASE FEEL FREE TO CALL CUSTOMER SERVICE AT
1-800-444-6222

III. OXFORD USA PRODUCT/PLAN DESIGN

A) Oxford USA (Non-gated POS plan design options – In-network and Out-of-network)

1. Plan Designs (No referrals are required for these plan designs)

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

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6	<input type="checkbox"/> Plan 7	<input type="checkbox"/> Plan 8	<input type="checkbox"/> Plan 9	<input type="checkbox"/> Plan 10
Copayment	\$10	\$15	\$15	\$15	\$20	\$20	\$20	\$25	\$15/\$25	\$25/\$40
Hospital Copayment	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$500 inpatient	\$100 inpatient \$100 outpatient	\$500 inpatient \$150 outpatient
Single Deductible	\$250	\$250	\$500	\$1,000	\$500	\$1,000	\$2,000	\$2,000	\$1,000	\$2,000
Family Deductible	\$625	\$625	\$1,250	\$2,500	\$1,250	\$2,500	\$5,000	\$5,000	\$2,500	\$5,000
Coinsurance	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Single Max. Out-of-Pocket	\$1,750	\$1,750	\$2,000	\$4,000	\$3,500	\$4,000	\$5,000	\$5,000	\$4,000	\$5,000
Out-of-Network	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹

2. Pharmacy Benefit:

Options	Tier 1	Tier 2	Tier 3	Mail Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$7 Copayment	\$20 Copayment	\$40 Copayment	2.5x Copayment	<input type="checkbox"/> \$0 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 2	\$10 Copayment	\$30 Copayment	\$60 Copayment	2.5x Copayment	<input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 3	\$15 Copayment	50%	50%	2.5x Copayment or 50%	<input type="checkbox"/> \$0 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> 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)

3. Additional Benefit Information:

- Vision
- Domestic Partner
- Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
- Unlimited Mental Health***

- In-network coverage is through UnitedHealthcare Choice Plus Network
- \$50 Emergency Room Copayment
- 90 Physical Therapy visits per condition, per lifetime

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

Dependent Student Eligibility Cutoff:

- Mandated Offering - Dependent Age Extension to 29
- Other: _____
SUBJECT TO HOME OFFICE APPROVAL

¹When a Medicare rate is not available, reimbursement is based upon certain 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. OXFORD USA PRODUCT/PLAN DESIGN (CONTINUED)

B) Oxford USA, (Freedom Plan Metro Access Non-gated – No referrals required)

1. Plan Designs (No referrals are required for these plan designs)

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

Options	<input type="checkbox"/> Option 1	<input type="checkbox"/> Option 2	<input type="checkbox"/> 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.

2. Pharmacy Benefit

Options	Tier 1	Tier 2	Tier 3	Mail Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$30 copayment	\$60 copayment	2.5x copayment	<input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2.5x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

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

3. Additional Benefit Options:

Vision

Domestic Partner

Other: _____

Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

Mandated Offering - Dependent Age Extension to 29

Unlimited Mental Health***

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.

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

C) Oxford USA (Freedom Plan Direct plan design options – NON-GATED)

1. Plan Designs (No referrals are required for these plan designs) In-network/Out-of-network

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4
Copayment	\$25/\$40	\$25/\$40	\$30/\$50	\$50/\$75
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 Max Out-of-Pocket	\$2,500/\$5,000	\$3,000/\$6,000	\$4,000/\$6,000	\$6,500/\$18,000

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

III. OXFORD USA PRODUCT/PLAN DESIGN(CONTINUED)

2. Pharmacy Benefit:

Options	Tier 1	Tier 2	Tier 3	Mail Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 Copayment	\$30 Copayment	\$60 Copayment	2.5x Copayment	<input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 2	\$15 Copayment	50%	50%	2.5x Copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$250
<input type="checkbox"/> 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)

3. Additional Benefit Information: Vision Domestic Partner Other: _____
SUBJECT TO HOME OFFICE APPROVAL

- 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.

Dependent Student Eligibility Cutoff: Mandated Offering - Dependent Age Extension to 29

D) Oxford USA HSA Direct

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

No referrals are required for these plan designs.

In-Network/Out-of-Network

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6
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%
Single Medical Maximum Out-of-Pocket	\$3,250/ \$6,000	\$3,000/ \$5,000	\$3,850/ \$5,850	\$1,250/ \$5,000	\$2,000/ \$5,000	\$2,850/ \$5,850
Family Medical Maximum Out-of-Pocket	\$6,500/ \$12,000	\$6,000/ \$10,000	\$7,700/ \$11,700	\$2,500/ \$10,000	\$4,000/ \$10,000	\$5,700/ \$11,700
Out-of-Network Reimbursement	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹	140% of Medicare Rate ¹

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

Additional Benefit Options:

Vision Domestic Partner Other: _____
SUBJECT TO HOME OFFICE APPROVAL

- Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
- Mandated Offering - Dependent Age Extension to 29
- 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.

III. OXFORD USA PRODUCT/PLAN DESIGN (CONTINUED)

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

Options	Tier 1	Tier 2	Tier 3	Mail-Order
<input type="checkbox"/> Option 1	\$10 copayment	\$30 copayment	\$60 copayment	2.5x copayment
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2.5x copayment or 50%

Contraceptives:

- Yes (Standard)
- No (Qualified State Exempt Groups Only)

****NOTE:** As of April 1, 2005, 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.

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. APPLICANT AGREEMENT

This Addendum forms a part of the Application between the Group and Us. In the event of a conflict between the provisions of this Addendum and the Application, the provisions of this Addendum will prevail. All other terms and conditions of the Application remain in full force and effect. Nothing contained in this Addendum will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Application to which this Addendum is attached, other than as specifically stated herein. 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.

Dated at: _____ this _____ day of _____ 20 _____

Oxford Health Insurance, Inc.

X

Signature of Authorized Officer of the Company

Title

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

Witness

Duly Licensed Resident Agent/Broker

