UnitedHealthcare®
Oxford

New Jersey Small Employer Oxford USA℠ Addendum

Oxford Health Insurance, Inc.
Mailing Address: NJ Small Group Enrollment Dept., 14 Central Park Drive, Hooksett, NH 03106 • 1-800-385-9088

I. POLICY HOLDER INFORMATION

Please print or type

Policy Number (OHI use only): _____

❑ New Policy ❑ Change in Policy Requested Effective Date: _____

1. Policyholder (full legal name of company):

2. Tax Identification Number:

	IN AREA	OUT OF AREA
3. Number of Employees Eligible on Effective Date:	_____	_____
Number of Employees Enrolling:	_____	_____

Please Note: *Maximum number of eligible employees cannot exceed 50% out of area*

4. Waiting Period before Employees Become Insured (May not exceed 6 months):

❑ Immediate on DOH ❑ 1 month after date of hire ❑ 2 months ❑ 3 months ❑ 6 months

II. OXFORD USA PRODUCT/UNITED CHOICE PLUS NETWORK/PLAN DESIGN

NOTE: Not all plan combinations are available. Please refer to the rate model or your Sales Representative to verify the plan combination you selected is available.

Options	❑ Plan C	❑ Plan D
Office Copayment	❑ $5 ❑ $10 ❑ $15 ❑ $15/$25 ❑ $20 ❑ $25/$40 ❑ $30 ❑ $40 ❑ $50	❑ $5 ❑ $10 ❑ $15 ❑ $20 ❑ $30
In-Network Coinsurance	❑ 80% ❑ 90% ❑ 100%	❑ 90% ❑ 100%
Out-Of-Network Deductible	❑ $200 ❑ $250 ❑ $300 ❑ $500 ❑ $750 ❑ $1,000 ❑ $2,500 ❑ $3,000 ❑ $3,500	❑ $200 ❑ $250 ❑ $300 ❑ $500 ❑ $750 ❑ $1,000
Coinsurance Maximum	❑ $5,000 ❑ $8,333 ❑ $10,000	❑ $5,000 ❑ $10,000

OPTIONS:

❑ Hospital Confinement at no charge ❑ Vision Care Rider
❑ Physical Therapy: 90 visits ❑ Domestic Partner

PRESCRIPTION DRUG BENEFITS

Copayment Information: ❑ Base Plan (Out-of-Network Deductible and Coinsurance)
❑ Standard (Plan Copayment)

Optional Riders (Tier 1/ Tier 2/ Tier 3 Copayment) ❑ $5/$15/$50* ❑ $7/$20/$50* ❑ $7/$15/$25 ❑ $7/$15/$35* ❑ $10/$25/$50*
❑ $15/50%* ❑ $15/$30/$60** ❑ $15/$35/$75* ❑ $25/$50/$75*

*Pharmacy Deductible (applies to Tier 2 and Tier 3 drugs): ❑ None ❑ $50 ❑ $100** (mandatory for $15/$30/$60)

III. OXFORD USA DIRECT PLAN DESIGNS

HEALTH BENEFITS

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6	❑ Plan 7	❑ Plan 8	❑ Plan 9	❑ Plan 10	❑ Plan 11
Copayment	$15 PCP / $25 Specialist	$25 PCP / $40 Specialist	$25 PCP / $40 Specialist	N/A	N/A	N/A	$15 PCP / $25 Specialist	$25 PCP / $40 Specialist	$25 PCP / $40 Specialist	$30 PCP / $50 Specialist	$30 PCP / $50 Specialist
Single Deductible	$500 / $1,000	$500 / $1,000	$1,000 / $2,000	$500 / $1,000	$2,000 / $2,000	$1,000 / $2,000	$1,000 / $2,000	$500 / $1,000	$1,000 / $2,000	$1,500 / $2,000	$2,500 / $2,500
Family Deductible	$1,000 / $2,000	$1,000 / $2,000	$2,000 / $4,000	$1,000 / $2,000	$4,000 / $4,000	$2,000 / $4,000	$2,000 / $4,000	$1,000 / $2,000	$2,000 / $4,000	$3,000 / $4,000	$5,000 / $5,000
Coinsurance	90%/70%	80%/60%	80%/60%	90%/70%	90%/70%	80%/60%	100%/70%	100%/70%	100%/70%	80%/60%	80%/60%
Single Max Out-of-Pocket	$1,500 / $4,000	$2,500 / $5,000	$3,000 / $6,000	$1,500 / $4,000	$3,000 / $5,000	$3,000 / $6,000	$1,000 / $5,000	$500 / $4,000	$1,000 / $5,000	$3,500 / $6,000	$4,500 / $6,500
Family Max Out-of-Pocket	$3,000 / $8,000	$5,000 / $10,000	$6,000 / $12,000	$3,000 / $8,000	$6,000 / $10,000	$6,000 / $12,000	$2,000 / $10,000	$1,000 / $8,000	$2,000 / $10,000	$7,000 / $12,000	$9,000 / $13,000

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

DIRECT OPTIONS:

❑ Vision Care Rider ❑ Domestic Partner

PRESCRIPTION DRUG BENEFITS

❑ Base Plan (Out-of-Network Deductible and Coinsurance)

❑ Plan Copayment (Available only with office visit Copayment plans)

Optional Riders (Tier 1/ Tier 2/ Tier 3)

❑ $7/$15/$25 ❑ $10/$25/$50* ❑ $15/50%* ❑ $5/$15/$50* ❑ $7/$20/$50*

❑ $7/$15/$35* ❑ $15/$30/$60** ❑ $15/$35/$75* ❑ $25/$50/$75*

*Pharmacy Deductible (applies to Tier 2 and Tier 3 drugs): ❑ None ❑ $50 ❑ $100** (mandatory for $15/$30/$60)

IV. OXFORD USA HSA DIRECT PLAN DESIGNS

OXFORD® HSA DIRECT℠

Note: Groups enrolling in the Oxford HSA Direct must also fill out an Oxford HSA Banking Notification Form (#7423)

HEALTH BENEFITS:

Options	Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6
Single Deductible** (In-network/Out-of-network)	$1,250/$2,000	$2,000/$2,000	$2,500/$2,500	$1,250/$2,000	$2,000/$2,000	$2,500/$2,500
Family Deductible** (In-network/Out-of-network)	$2,500/$4,000	$4,000/$4,000	$5,000/$5,000	$2,500/$4,000	$4,000/$4,000	$5,000/$5,000
Coinsurance (In-network/Out-of-network)	80%/60%	90%/70%	90%/70%	100%/70%	100%/70%	100%/70%
Single Medical Out-of-pocket Maximum (In-network/ Out-of-network) (Family = 2x)	$3,250/$6,000	$3,000/$5,000	$3,500/$5,500	$1,250/$5,000	$2,000/$5,000	$2,500/$5,500

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

PRESCRIPTION DRUG BENEFITS** (REQUIRED):

Tier 1/ Tier 2/ Tier 3 Copayment (once the in-network deductible has been satisfied)

❑ $7/$15/$35 ❑ $10/$25/$50 ❑ $15/50% ❑ $25/$50/$75

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

**NOTE: All in-network medical and pharmacy services are subject to the in-nework 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.

OXFORD HSA DIRECT OPTIONS (ALL INFORMATION IS SUBJECT TO HOME OFFICE APPROVAL)

❑ Vision ❑ Domestic Partner ❑ Physical Therapy 90 Rider (30 visits standard)

V. SIGNATURE

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.

Dated at:_____ on_____

_____ _____

Print Name of Officer, Partner or Proprietor Signature of Officer, Partner or Proprietor

_____

Witness to Signature

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.