UnitedHealthcare Oxford

Freedom Plan® Classic℠ Liberty Plan℠ Classic
Freedom Plan® Access℠ Liberty Plan℠ Access
Freedom Plan® Direct℠ Liberty Plan℠ Direct
Oxford USA℠ Oxford® HSA Direct℠
NJ Public Sector Oxford MyPlan℠

New Jersey Large Employer Application - OHI

Oxford Health Insurance, Inc.
Mailing Address: 48 Monroe Turnpike, Trumbull, CT 06611 • www.oxfordhealth.com

I. GENERAL INFORMATION

1. Full legal name of firm:

2. Address of firm:
   (Street Address
   City, State, Zip Code)
   Please do not use P.O. Box

3. **Plan Administrator/Contact:**
   a. Name and Title:
   b. Address:
   (If it differs from address of firm; cannot be a P.O. Box)
   c. Phone Number:
   d. Fax Number:
   e. Email address:

4. **Name and title of person to receive correspondence/billing statements:**
   a. Name:
   b. Title:
   c. Address:
   (Street Address
   City, State, Zip Code)
   d. Phone Number:
   e. Fax Number:

5 **Start date of business:**

6. **Full legal name & address of Parent Company**
   a. Name:
   b. Address:
   (Street Address
   City, State, Zip Code)

7. **Full legal name & address of each subsidiary and/or affiliated company, branch or satellite office whose employees are to be covered:**
   a. Name:
   b. Address:
   (Street Address
   City, State, Zip Code)

Name of Company: _____

8. **Nature of business:**

9. **SIC Code:** _____

10. **Tax Identification Code or Number:**

    a. Federal I.D. _____

    b. State Tax I.D. _____

II. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate.

1. **Effective date:** We request that this coverage be effective as of the first day of _____ (Month/Year).

2. **Anniversary date:** The anniversary date will fall annually on the first day of the calendar month of the approved effective date.

3. **Other group health or Individual coverage:** Indicate below other health coverage which is still in force or that has terminated within the past three (3) years.

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

4. **Employee Contributions**

Toward Employee Premium: _____%

Toward Family Premium: _____%

*** Employer contribution must be at least 50% towards Employee premium.**

5. **Eligibility and Termination:** Each employee must be eligible on the date the insurance provided under the Certificate becomes effective with respect to him/her. If the employee is not eligible for coverage on the date the Certificate becomes effective, the employee must wait until he/she is eligible for coverage.

a) **Employee Eligibility:**

Full-time Employees: All permanent, full-time employees who work at least _____ hours per week (minimum 30 hours/week).

Are any classes excluded? ❑ Yes ❑ No

If yes, indicate classes excluded: _____

_____

Part-time Employees: ❑ Yes, part-time employees who work at least _____ hours per week (minimum 20 hours per week).

❑ Not Covered

Retired Employees: ❑ Covered ❑ Not Covered

The definition of a Retired Employee is:

- ❑ an employee who is retired on pension by the employer.
- ❑ an employee who is retired on pension by the employer and who immediately prior to the date of retirement had completed at least_____years of service with the employer.
- ❑ an employee who is retired from service by the employer and who immediately prior to the date of retirement had completed at least_____years of service with the employer.

Name of Company: _____

b) **Eligibility & 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

Waiting Period (Please enter zero for no waiting period)

❑ * _____ month(s) of continuous service, or

❑ * _____ days of continuous service.

***6 month maximum**

Effective Date of Coverage (Please select one)

❑ Date on which the employee completes the waiting period.

❑ On the first day of the calendar month coinciding with completion of the waiting period. (e.g., the employee will complete the waiting period on 2/15 and will therefore, be eligible to enroll on 2/1).

❑ On the first day of the month following the date on which the employee completes the waiting period. (e.g., the employee will complete the waiting period on 2/15 and will therefore, be eligible to enroll on 3/1).

ii) Termination

❑ Date of termination of employment.

❑ On the last day of the calendar month in which employee's employment terminates.

iii) Waiting Period for Rehires

Waiting Period Waived for Rehires? ❒ **Yes** ❒ **No**
If yes, waived if rehired within _____month(s).

iv) Waiting Period for Full-time Employees

Waiting Period Waived for existing Full-Time employees?
❒ **Yes** ❒ **No**

v) Dependent Cut-Off

❒ End of Semester
❒ End of Calendar Year
❒ Other (requires Home Office approval)

CLASS II

Definition of Class II _____

_____

i) Eligibility

Waiting Period (Please enter zero for no waiting period)

❑ * _____ month(s) of continuous service, or

❑ * _____ days of continuous service.

***6 month maximum**

Effective Date of Coverage (Please select one)

❑ Date on which the employee completes the waiting period.

❑ On the first day of the calendar month coinciding with completion of the waiting period. (e.g., the employee will complete the waiting period on 2/15 and will therefore, be eligible to enroll on 2/1).

❑ On the first day of the month following the date on which the employee completes the waiting period. (e.g., the employee will complete the waiting period on 2/15 and will therefore, be eligible to enroll on 3/1).

ii) Termination

❑ Date of termination of employment.

❑ On the last day of the calendar month in which employee's employment terminates.

iii) Waiting Period for Rehires

Waiting Period Waived for Rehires? ❒ **Yes** ❒ **No**
If yes, waived if rehired within _____month(s).

iv) Waiting Period for Full-time Employees

Waiting Period Waived for existing Full-Time employees?
❒ **Yes** ❒ **No**

v) Dependent Cut-Off

❒ End of Semester
❒ End of Calendar Year
❒ Other (requires Home Office approval)

6. **Number of Employees Eligible on Effective Date:** Full-time Employees _____ Part-time Employees _____ Retired Employees _____

7. **Coordination of Benefits:** To the extent permitted by law, all health expense benefits will be coordinated with benefits under any No-fault Auto Plan, under any other Group Plan and under any Group-type Plan.

8. **Integration with Medicare Benefits:** Health Benefits will be integrated with Medicare Benefits for Retired Employees age 65 or over and their dependents age 65 or over if the group offers retiree coverage.

9. **Dependent Eligibility:** Dependents are defined as follows: • a legal spouse; and • any child who has not reached age 19 or 24, and who is not married; and who is chiefly dependent upon the employee for support.

The term "child" means the employee's children, including any legal stepchild, legally or proposed adoptive child who is physically placed in subscribers home, or child for whom the employee or employee's spouse is the court appointed legal guardian.

If a child is a registered full-time student at a university, college, or similar institution of higher learning, then that child will be covered until the earlier of:
• the date on which he/she is no longer a registered full-time student:
• the date he/she reaches age: ❒ 23 ❒ 24 *or* ❒ 25 (**Non-standard, additional cost**) (check one)

Name of Company: _____

If a child cannot support him/herself due to mental retardation or physical handicap, the age limitation requirement for such a child is waived provided that the disability or handicap arose prior to attaining the limiting age and the child is chiefly dependent upon the subscriber for economic support and
maintenance, provided proof of such incapacity and dependency is furnished to Oxford Health Plans within thirty-one (31) days of the child's attaining the limiting age. However, the child must have been covered under this plan or the prior plan on the day before his/her attaining the limiting age.

10. **Plan Exclusions and Limitations:** Please refer to your Group Certificate for a complete list of exclusions and limitations.

III. PRODUCT/PLAN DESIGN

Section 1: PLAN OPTIONS

1. **Please check the box corresponding to the product selected:**

Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application specifying the additional information.

- ❑ Liberty Schoolboard/Municipality Traditional Plan[3]
- ❑ Liberty Schoolboard/Municipality Access Plan[3]
- ❑ Liberty Schoolboard/Municipality Classic Plan[3]
- ❑ Freedom Plan Classic[1]
- ❑ Freedom Plan Access[1]
- ❑ Oxford USA (UnitedHealthcare Choice Plus Network)[1]
- ❑ Freedom Schoolboard/Municipality Traditional Plan[3]
- ❑ Freedom Schoolboard/Municipality Access Plan[3]
- ❑ Freedom Schoolboard/Municipality Classic Plan[3]
- ❑ Liberty Plan Classic[2]
- ❑ Liberty Plan Access[2]

2. **Please complete section below (please mark N/A if not applicable):**

Office Copayment: _____
Coinsurance %: _____
Family Multiple (2, 2.5, 3): _____

Deductible: _____
Maximum Out-of-Pocket: _____
Out-of-Network Reimbursement- Freedom and Oxford USA[1]: _____
Out-of-Network Reimbursement- Liberty: based upon 140% of Medicare Rate[2]
Out-of-Network Reimbursement- Schoolboard/ Municipality all plans: based upon Very High fee schedule[3]

3. **Additional Benefit Information (All information is subject to Home Office approval):**

Prescription Plan : ❑ Yes ❑ No

Copayment Information:

Deductible: _____
Tier 1: _____
Tier 2: _____
Tier 3: _____

Mail-Order Prescription Drug Plan: ❒ Yes ❒ No (if applicable)
Oral Contraceptives: ❒ Yes ❒ No

- ❒ Vision Reimbursement: _____
- ❒ 30 Visits Outpatient Mental Health
- ❒ Enhanced Chiropractic Services ($1,000 limit Out-of-Network)
- ❒ Dental Plan Enhanced
- ❒ Exercise Facility
- ❒ Dependent Age Extension to 29
- ❒ 90 Visits Outpatient Physical Therapy
- ❒ Unlimited Skilled Nursing Facility
- ❒ Dental Plan Premium
- ❒ Emergency Room Copayment _____
- ❒ Inpatient/Outpatient Hospital Copayment

Other: _____

Name of Company: _____

III. PRODUCT/PLAN DESIGN (CONTINUED)

Section 2: FREEDOM PLAN DIRECT AND LIBERTY PLAN DIRECT PLAN DESIGNS

No referrals are required for these plan designs.

1. **Please check the box corresponding to the product selected:**
   Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application specifying the additional information.

   - ❑ Freedom Plan Direct (Office Visit Copayment)
   - ❑ Freedom Plan Direct (Deductible & Coinsurance only)
   - ❑ Liberty Plan Direct (Office Visit Copayment)
   - ❑ Liberty Plan Direct (Deductible & Coinsurance only)
   - ❑ Oxford USA (Office Visit Copayment)
   - ❑ Oxford USA (Deductible & Coinsurance only)

2. **Please complete section below (if applicable):**

   Office Visit Copayment: _____

   In-network

   Deductible: _____
   Coinsurance: _____
   Coinsurance Maximum: _____

   Out-of-network

   Deductible: _____
   Coinsurance: _____
   Coinsurance Maximum: _____
   Out-of-Network Reimbursement- Freedom and Oxford USA: based upon Standard fee schedule[1]
   Out-of-Network Reimbursement- Liberty: based upon 140% of Medicare Rate[2]

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

3. **Additional Benefit Information (All information is subject to Home Office approval):**

   Prescription Drug Plan: ❑ Yes ❑ No

   Copayment Information

   Deductible: _____

   Tier 1: _____ Tier 2: _____ Tier 3: _____

   Mail-Order Prescription Drug Plan: ❑ Yes ❑ No Oral Contraceptives: ❑ Yes ❑ No

   - ❑ Vision Reimbursement _____
   - ❑ 30 Visits Outpatient Mental Health (Non-biological)
   - ❑ Enhanced Chiropractic Services ($1,000 Limit Out-of-Network)
   - ❑ Emergency Room Copayment _____
   - ❑ 90 Visits Outpatient Physical Therapy

   Skilled Nursing Facility ❑ Unlimited ❑ 100 days per calendar year

   - ❑ Domestic Partner
   - ❑ Dependent Age Extension to 29
   - ❑ Other (Subject to Home Office Approval): _____

Name of Company: _____

III. PRODUCT/PLAN DESIGN (CONTINUED)

Section 3: Oxford MyPlan Options

Note: Groups enrolling in Oxford MyPlan must also fill out an Oxford MyPlan Health Reserve Account Application (form #6740).

1. Please check the box corresponding to the product selected:

Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application specifying the additional information.

Please Select Network: ❑ Freedom ❑ Liberty

❑ Oxford MyPlan (Office Visit Copayment) ❑ Oxford MyPlan (Deductible & Coinsurance only)

Please Note: No referrals are required for these plan designs.

2. Please complete section below (please mark N/A if not applicable):

❑ Office Visit Copayment: _____ ❑ None (Deductible & Coinsurance only)

In-network

Deductible: _____

Coinsurance: _____

Coinsurance Maximum: _____

Out-of-network

Deductible: _____

Coinsurance: _____

Coinsurance Maximum: _____

Out-of-Network Reimbursement- Freedom: based upon Standard fee schedule[1]

Out-of-Network Reimbursement- Liberty: based upon 140% of Medicare Rate[2]

Please Note: Family deductible and out-of-pocket expenses are two times the single amount.

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

3. Additional Benefit Information (All information is subject to Home Office approval):

Prescription Drug Plan: ❑ Yes ❑ No

Copayment Information

Deductible: _____

Tier 1: _____ Tier 2: _____ Tier 3: _____

Mail-Order Prescription Drug Plan: ❑ Yes ❑ No Oral Contraceptives: ❑ Yes ❑ No

❑ Vision Reimbursement _____

❑ Dependent Age Extension to 29

Name of Company: _____

III. PRODUCT/PLAN DESIGN (CONTINUED)

Section 4: Oxford HSA Direct Options

No referrals are required for these plan designs.

Groups enrolling in the Oxford HSA Direct are required to fill out a Certificate of Understanding Form (#8767). For groups electing to use OptumHealthBank, an Oxford HSA Employer Notification Form (#7423) must be completed.

1. Please select network:

❑ Freedom ❑ Liberty ❑ Oxford USA (First Health Network)

2. **Please complete section below:**

In-network

Deductible: _____

Coinsurance: _____

Coinsurance Maximum: _____

Out-of-network

Deductible: _____

Coinsurance: _____

Coinsurance Maximum: _____

Out-of-Network Reimbursement- Freedom and Oxford USA: based upon Standard fee schedule[1]

Out-of-Network Reimbursement- Liberty: based upon 140% of Medicare Rate[2]

Prescription Drug Plan (Required) **

Copayment Information

Tier 1: _____ Tier 2: _____ Tier 3: _____

Mail-Order Prescription Drug Plan: ❑ Yes ❑ No Oral Contraceptives: ❑ Yes ❑ No

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

3. **Additional Benefit Information (All information is subject to Home Office approval):**

❑ Vision Reimbursement _____

❑ 30 Visits Outpatient Mental Health (Non-biological)

❑ Enhanced Chiropractic Services ($1,000 Limit Out-of-Network)

❑ 90 Visits Outpatient Physical Therapy

Skilled Nursing Facility ❑ Unlimited ❑ 100 days per calendar year

❑ Domestic Partner

❑ Dependent Age Extension to 29

❑ Other (Subject to Home Office Approval): _____

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

Name of Company: _____

IV. UNDERWRITING GUIDELINES

The undersigned authorized officer of the Applicant hereby confirms that the Applicant satisfies, and if this Application is accepted by Oxford, will continue to satisfy and remain in compliance with the Underwriting Guidelines set forth in Attachment A, hereto, and any additional underwriting guidelines that Oxford may promulgate and which Applicant is given notice of in conjunction with future renewals. The Applicant hereby acknowledges that if at any time it is not in compliance with such underwriting guidelines or if any census data provided by the Applicant to Oxford, in conjunction with this Application for coverage do not accurately reflect, in the judgment of Oxford, the actual Applicant members covered by Oxford, on the date coverage by Oxford first commences, then Oxford shall have the right, at any time upon 30 days written notice to the Applicant, to increase the monthly premiums payable by the Applicant in such amount as is determined by Oxford, in its absolute discretion, to reflect the increased risk of such non-compliance or census variance.

Name of Company

X _____

Signature of Authorized Officer of Company | Title of Officer of Company | Date

V. COBRA AND EXTENSION OF BENEFITS

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? _____

VI. APPLICANT AGREEMENT

This Application and the premium rates proposed by Oxford are subject to Home Office 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. The Applicant hereby acknowledges that this Application does not constitute any obligation by Oxford to offer coverage to the Applicant until such Application is accepted, in writing, by the Home Office of Oxford. 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, and that Oxford shall have no obligation to provide coverage to the Applicant unless this Application is formally accepted, in writing, by the Oxford Home Office. Further, I hereby certify on behalf of the Applicant that the Applicant has not had a health insurance policy terminated within the past 12 months due to failure to pay premiums.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at:_____this_____day of_____20_____.

Applicant Name (full legal Name)

X _____

Signature of Authorized Officer of the Applicant | Title of Officer of the Applicant

X _____

Witness | Duly Licensed Resident Agent/Broker

[1]The Standard, High and Very High UCR fee schedules contain the maximum allowable fees and are set using data from Ingenix, Inc., the Centers for Medicare and Medicaid Services (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees. Physician fees are generally set using data from the Prevailing Healthcare Charges System (PHCS) database maintained by Ingenix. We use 70th percentile PHCS data for the standard UCR fee schedule, 80th percentile PHCS data for the high UCR fee schedule, and 90th percentile PHCS data for the very-high UCR fee schedule. We and Ingenix are related companies through common ownership by UnitedHealth Group. The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees. Standard UCR applies for all out-of-network Covered Services except for those noted below:

- Inpatient & Outpatient Hospital 150% of Medicare
- Free-Standing Ambulatory Surgical Centers 225% of Medicare
- Free-Standing Lab & Radiology Services 150% of Medicare

[2]When 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.

[3]The Very High UCR fee schedules contains the maximum allowable fees and is set using data from Ingenix, Inc., the Centers for Medicare and Medicaid Services (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees. Physician fees are generally set using 90th percentile data from the Prevailing Healthcare Charges System (PHCS) database maintained by Ingenix. We and Ingenix are related companies through common ownership by UnitedHealth Group. The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees.