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.

Oxford Health Plans (NJ), Inc./Oxford Health Insurance, Inc.

Temporary HINT Supplemental Enrollment Information Form Implementing P.L. 2005, c. 375

A. Group & Employee Information

Group Name: ____

Group Number: _______________

Employee Name: ____

Employee ID Number: ____________________

B. Type of Activity (see Important Explanatory Information below)

Date of Event | Change-Check all that apply

____/_____/_____ ☐ Add dependent over the limiting age, but less than 30

____/_____/_____ ☐ Remove dependent over the limiting age, but less than 30

Reasons:

____

____

____/_____/_____ Continuation of Coverage pursuant to P.L. 2005, c. 375

Coverage is being effected:

☐ During an Open Enrollment

☐ Within 30 days prior to attainment of limiting age

☐ Within 30 days after eligibility for other reasons

☐ During special 12-month enrollment

C. Over-age Dependent Information

Name (last, first, MI) ____ Sex: ☐ M ☐ F

Address ____

City _____________________________________ST ________ Zip _______________

Birthdate: (MM, DD, YY) ____/____/____ SSN: _____________________

Other Health Coverage: ☐ Yes ☐ No Other Rx Drug Coverage: ☐ Yes ☐ No

Primary Office ID Number: _________________________Current Patient: ☐ Yes ☐ No

Ob/Gyn Office ID Number:_____________________Current Patient: ☐ Yes ☐ No ☐ N/A

Previous Coverage: ☐ Yes ☐ No

If yes, provide the following information AND submit a copy of the certificate of Creditable Coverage that was issued by the previous carrier, if available:

Effective date of prior coverage: ___/___/___

Termination date of prior coverage: ___/___/___

Name of prior carrier: ____

Prior plan number: ______________________________

Important Information Regarding Your Plan

As permitted by law, Oxford has chosen to administer the over-age dependent coverage as a "stand-alone" plan. This means that charges incurred by the over-age dependent are separated from those charges incurred by other members of the family covered on the policy. The over-age dependent's charges do not apply toward meeting the family deductible, out-of-pocket maximum or other cost-sharing requirements or limitations applicable to the other family members as a unit. Instead, the over-age dependent's covered charges are applied towards meeting a deductible, out-of-pocket maximum or other cost-sharing requirements and limitations as if the over-age dependent had single coverage under the group plan.

D. Signature

______________________________________	____
Employee	Dependent
__________________	___________________
Date	Date

IMPORTANT EXPLANATORY INFORMATION

An adult child may request to continue as a dependent on his or her parent's coverage even after the child reaches the limiting age under the terms of the policy if the adult child:

- is not yet 30 years old
- is unmarried
- has no children
- lives in New Jersey or, if not a New Jersey resident, is a full-time student at an accredited institution of higher education
- is not eligible for Medicare and is not actually covered under another group or individual health plan.

An adult child may make the request to continue as a dependent on his or her parent's coverage either:

- when he or she first reaches the limiting age
- when he or she first becomes eligible for a reason other that reaching the limiting age (for example, the adult child becomes a full-time student in another state, or returns to live in New Jersey after residing elsewhere), or
- during the open enrollment period for the group of which the parent is a member.

In addition, adult children who reached the limiting age under the parent's coverage prior to May 12, 2006 may make an enrollment request at any time from May 12, 2006 through May 11, 2007.

The adult child or covered employee may be required to pay up to 102% of the cost of the dependent premium.