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. Did you have any employees other than yourself and your spouse during the preceding calendar year? ❒ Yes ❒ No
6. 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 17 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.
7. 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 question17 below.

   Groups seeking to purchase insurance, rather than HMO coverage, also must meet the minimum participation requirements for coverage. Please see our underwriting guidelines for details on our minimum participation requirements.
8. 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.
9. 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? ____
10. 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 (include number of eligible employees enrolling in other employer-sponsored HMO coverage): __________
11. Total number of valid waivers (a - d): _____________________
12. Enter the Prior Calendar Year Average Total Number of Employees ________

    Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for whom the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.

    To calculate the annual average, add all the monthly employee totals together then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the

number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

13. Is the Employer offering other group health insurance coverage to employees who are eligible for coverage in an Oxford product? (check no if group only offers other HMO coverage) ❒ 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

14. 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

15. Subject to ERISA? ❒ Yes ❒ No
    If No, please indicate appropriate category:
    - ❒ Church
    - ❒ Indian Tribe – Commercial Business
    - ❒ Foreign Government/Foreign Embassy
    - ❒ Federal Government
    - ❒ Non-Federal Government (State, Local or Tribal Gov.)
    - ❒ Non-ERISA Other ___________________________

16. Does your group sponsor a plan that covers employees of more than one employer? ❒ Yes ❒ No
    If you answered Yes, then indicate which of the following most closely describes your plan:
    - ❒ Professional Employer Organization (PEO)
    - ❒ Multiple Employer Welfare Arrangement (MEWA)
    - ❒ Taft Hartley Union
    - ❒ Governmental
    - ❒ Church
    - ❒ Employer Association

17. 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. Platinum Plans

Option	❑ Platinum Standard EPO 15/35*	❑ Platinum EPO 10/20	❑ Platinum EPO 20/30
Network	Liberty	Freedom	Freedom
Copayment:			
a. PCP	$15 per visit	$10 per visit	$20 per visit
b. Specialist	$35 per visit	$20 per visit	$30 per visit
In-network Deductible (Single/Family)	N/A	N/A	N/A
In-network Maximum Out-of-Pocket (Single/Family)	$2,000/$4,000	$3,000/$6,000	$3,000/$6,000
In-network Coinsurance	10%	N/A	N/A
Outpatient Facility Copayment	Freestanding Facility - $100 Hospital Facility - $100	Freestanding Facility - $50 Hospital Facility - $100	Freestanding Facility - $100 Hospital Facility - $300
Inpatient Facility Copayment	$500 per admission	$150 per admission	$500 per admission
Emergency Room	$100	$100	$150
Prescription Drug Coverage	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible – N/A	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible** – $100/$200 **❑ Option 2** Tier 1 – $10 copayment Tier 2 – 20% copayment to $150 maximum Tier 3 – 35% copayment to a $400 maximum Mail-Order - 2.5x copay Deductible** – $100/$200	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible** – $100/$200 **❑ Option 2** Tier 1 – $10 copayment Tier 2 – 20% copayment to $150 maximum Tier 3 – 35% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible** – $100/$200

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Platinum Plans (Continued)

Option	❑ Platinum Standard PPO 15/35*	❑ Platinum PPO 10/20	❑ Platinum PPO 20/30
Network	Liberty	Freedom	Freedom
Copayment:			
a. PCP	$15 per visit	$10 per visit	$20 per visit
b. Specialist	$35 per visit	$20 per visit	$30 per visit
In-network Deductible (Single/Family)	N/A	N/A	N/A
In-network Maximum Out-of-Pocket (Single/Family)	$2,000/$4,000	$3,000/$6,000	$3,000/$6,000
In-network Coinsurance	10%	N/A	N/A
Outpatient Facility Copayment	Freestanding Facility - $100 Hospital Facility - $100	Freestanding Facility - $50 Hospital Facility - $100	Freestanding Facility - $100 Hospital Facility - $300
Inpatient Facility Copayment	$500 per admission	$150 per admission	$500 per admission
Emergency Room	$100	$100	$150
Out-of-network Deductible (Single/Family)	$2,000/$4,000	$1,000/$2,000	$2,000/$4,000
Out-of-network Maximum Out-of-Pocket (Single/Family)	$5,000/$10,000	$2,500/$5,000	$5,000 /$10,000
Out-of-network Coinsurance	30%	30%	30%
Prescription Drug Coverage	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible – N/A	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order - 2.5x copay Deductible**– $100/$200 **❑ Option 2** Tier 1 – $10 copayment Tier 2 – 20% copayment to $150 maximum Tier 3 – 35% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible**– $100/$200	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible**– $100/$200 **❑ Option 2** Tier 1 – $10 copayment Tier 2 – 20% copayment to $150 maximum Tier 3 – 35% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible**– $100/$200

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

* Referrals are required for this plan design. Deductibles and out-of-pocket accumulate on calendar year basis only.
** Deductible applies to Tier 2 and Tier 3 drugs.

Additional Benefit Options:

❑ Domestic Partner

❑ Mandated Offering – Dependent Age Extension to 29

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)

B. Gold Plans

Option	❑ **Gold Standard EPO 25/40***	❑ **Gold EPO 15/25**	❑ **Gold EPO 20/40**
Network	❑ Liberty	❑ Freedom ❑ Liberty	❑ Freedom ❑ Liberty
Copayment:			
a. PCP	Deductible then $25 per visit	$15 per visit	$20 per visit
b. Specialist	Deductible then $40 per visit	$25 per visit	$40 per visit
In-network Deductible (Single/Family)	$600/$1,200	$800/$1,600	$1,250/$2,500
In-network Maximum Out-of-Pocket (Single/Family)	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000
In-network Coinsurance	20%	10%	10%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $100 Hospital Facility – Deductible then $100	Freestanding Facility - $150 Hospital Facility - $250	Freestanding Facility - $150 Hospital Facility - $250
Inpatient Facility Copayment	Deductible then $1,000 per admission	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	Deductible then $150	$200	$200
Prescription Drug Coverage	❑ **Option 1** Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $70 copayment Mail-Order – 2.5x copay Deductible – N/A	❑ **Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100/$200 ❑ **Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $150 maximum Tier 3 – 40% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible** – $100/$200	❑ **Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100/$200 ❑ **Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $150 maximum Tier 3 – 40% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible** – $100/$200

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Gold Plans (Continued)

Option	❑ **Gold EPO HSA $1500*** **	❑ **Gold EPO 50**	❑ **Gold Primary Advantage $500 25/50*** **
Network	❑ Freedom	❑ Freedom	❑ Liberty
Copayment:			
a. PCP	10% after Deductible has been met	$50 per visit	$25 per visit
b. Specialist	$10% after Deductible has been met	$50 per visit	Deductible then $50 per visit
In-network Deductible (Single/Family)	$1,500/$3,000	$750/$1,500	$500/$1,000
In-network Maximum Out-of-Pocket (Single/Family)	$2,000/$4,000	$4,000/$8,000	$4,000/$8,000
In-network Coinsurance	10%	N/A	N/A
Outpatient Facility Copayment	10% after Deductible has been met	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250
Inpatient Facility Copayment	10% after Deductible has been met	Deductible then $250 per day to $2,500 maximum	Deductible then $250 per day to $1,250 maximum per admission ($2,500 per year)
Emergency Room	10% after Deductible has been met	$250	Deductible then $250
Prescription Drug Coverage	❑ **Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible*** ❑ **Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $150 maximum Tier 3 – 40% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible***	❑ **Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100/$200 ❑ **Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $150 maximum Tier 3 – 40% copayment to a $400 maximum Mail-Order - 2.5x copay Deductible** – $100/$200	❑ **Option 1** Tier 1 – $15 copayment Tier 2 – Deductible then $35 copayment Tier 3 – Deductible then $75 copayment Mail-Order – 2.5x copay Deductible** ❑ **Option 2** Tier 1 – $15 copayment Tier 2 – Deductible then 25% copayment to $150 maximum Tier 3 – Deductible then 40% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible**

III. PRODUCT AND PLAN DESIGNS (CONTINUED) CONTINUED

Gold Plans (Continued)

Option	❑ Gold PPO 25/40	❑ Gold PPO HSA $1500***
Network	❑ Freedom	❑ Freedom
Copayment:		
a. PCP	$25 per visit	10% after Deductible has been met
b. Specialist	$40 per visit	$10% after Deductible has been met
In-network Deductible (Single/Family)	$1,000/$2,000	$1,500/$3,000
In-network Maximum Out-of-Pocket (Single/Family)	$4,000/$8,000	$2,000/$4,000
In-network Coinsurance	20%	10%
Outpatient Facility Copayment	Freestanding Facility - $150 Hospital Facility - $250	10% after Deductible has been met
Inpatient Facility Copayment	20% after Deductible has been met	10% after Deductible has been met
Emergency Room	$200	10% after Deductible has been met
Out-of-network Deductible (Single/Family)	$2,000/$4,000	$3,000/$6,000
Out-of-network Maximum Out-of-Pocket (Single/Family)	$5,000/$10,000	$7,500/$15,000
Out-of-network Coinsurance	40%	40%
Prescription Drug Coverage	**❑ Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100/$200 **❑ Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $150 maximum Tier 3 – 40% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible** – $100/$200	**❑ Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible*** **❑ Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $150 maximum Tier 3 – 40% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible***

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

* Referrals are required for this plan design. Deductibles and out-of-pocket accumulate on calendar year basis only.
** Deductible applies to Tier 2 and Tier 3 drugs.
***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 has been met.

Additional Benefit Options:

❑ Domestic Partner

❑ Mandated Offering – Dependent Age Extension to 29

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. Silver Plans

Option	❑ **Silver Standard EPO 30/50***	❑ **Silver Primary Advantage $1500 25/50***	❑ **Silver EPO HSA $2000***
Network	Liberty	Liberty	❑ Liberty ❑ Freedom
Copayment:			
a. PCP	Deductible then $30 per visit	$25 per visit	Deductible & Coinsurance
b. Specialist	Deductible then $50 per visit	Deductible then $50 per visit	Deductible & Coinsurance
In-network Deductible (Single/Family)	$2,000/$4,000	$1,500/$3,000	$2,000/$4,000
In-network Maximum Out-of-Pocket (Single/Family)	$5,500/$11,000	$5,500/$11,000	$6,000/$12,000
In-network Coinsurance	30%	N/A	20%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $100 Hospital Facility – Deductible then $100	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250	Deductible & Coinsurance
Inpatient Facility Copayment	Deductible then $1,500 per admission	Deductible then $250 per day to a maximum of $1,250 per admission	Deductible & Coinsurance
Emergency Room	Deductible then $150	Deductible then $250	Deductible & Coinsurance
Prescription Drug Coverage	❑ **Option 1** Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $70 copayment Mail-Order – 2.5x copay Deductible – N/A	❑ **Option 1** Tier 1 – $15 copayment Tier 2 – Deductible then $35 copayment Tier 3 – Deductible then $75 copayment Mail-Order – 2.5x copay Deductible** ❑ **Option 2** Tier 1 – $15 copayment Tier 2 – Deductible then 25% copayment to $150 maximum Tier 3 – Deductible then 40% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible**	❑ **Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible*** ❑ **Option 2** Tier 1 – $15 copayment Tier 2 – 25% copay to $150 maximum Tier 3 – 40% copay to a $400 maximum Mail-Order – 2.5x copay Deductible***

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Silver Plans (Continued)

Option	❑ **Silver EPO HSA $2000 25/50*** **	❑ **Silver EPO 40/70**
Network	❑ Liberty ❑ Freedom	❑ Liberty ❑ Freedom
Copayment:		
a. PCP	Deductible then $25 per visit	$40 per visit
b. Specialist	Deductible then $50 per visit	$70 per visit
In-network Deductible (Single/Family)	$2,000/$4,000	$2,000/$4,000
In-network Maximum Out-of-Pocket (Single/Family)	$5,500/$11,000	$6,350/$12,700
In-network Coinsurance	20%	30%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250
Inpatient Facility Copayment	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	Deductible then $250	Deductible & Coinsurance
Prescription Drug Coverage	❑ **Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible*** ❑ **Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $150 Maximum Tier 3 – 40% copayment to a $400 Maximum Mail-Order – 2.5x copay Deductible***	❑ **Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100/$200 ❑ **Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $150 maximum Tier 3 – 40% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible** – $100/$200

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Silver Plans (Continued)

Option	❑ Silver Standard PPO 30/50*	❑ Silver PPO HSA $2000 30/60***	❑ Silver PPO 40/70
Network	Liberty	Freedom	❑ Liberty ❑ Freedom
Copayment:			
a. PCP	$30 per visit	Deductible then $30 per visit	$40 per visit
b. Specialist	$50 per visit	Deductible then $60 per visit	$70 per visit
In-network Deductible (Single/Family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
In-network Maximum Out-of-Pocket (Single/Family)	$5,500/$11,000	$5,500/$11,000	$6,350/$12,700
In-network Coinsurance	30%	10%	30%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $100 Hospital Facility – Deductible then $100	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250
Inpatient Facility Copayment	Deductible then $1,500 per admission	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	Deductible then $150	Deductible & Coinsurance	Deductible & Coinsurance
Out-of-network Deductible (Single/Family)	$3,000/$6,000	$4,000/$8,000	$4,000/$8,000
Out-of-network Maximum Out-of-Pocket (Single/Family)	$7,500/$15,000	$10,000/$20,000	$10,000/$20,000
Out-of-network Coinsurance	30%	50%	50%
Prescription Drug Coverage	**❑ Option 1** Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $70 copayment Mail-Order – 2.5x copay Deductible – N/A	**❑ Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible*** **❑ Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $150 maximum Tier 3 – 40% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible***	**❑ Option 1** Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100/$200 **❑ Option 2** Tier 1 – $15 copayment Tier 2 – 25% copayment to $150 maximum Tier 3 – 40% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible** – $100/$200

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

* All in-network medical services are subject to the in-network deductible. Deductibles and out-of-pocket accumulate on calendar year basis only. Referrals are required for this plan design.

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

***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 has been met.

Additional Benefit Options:

❑ Domestic Partner

❑ Mandated Offering – Dependent Age Extension to 29

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. Bronze Plans

Option	❑ Bronze Standard EPO $3000*	❑ Bronze EPO HSA $5000***	❑ Bronze EPO HSA $3500 40/75 ***	❑ Bronze PPO HSA $3750***
Network	Liberty	❑ Liberty ❑ Freedom	Liberty	Liberty
Copayment:				
a. PCP	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $40 per visit	Deductible & Coinsurance
b. Specialist	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $75 per visit	Deductible & Coinsurance
In-network Deductible (Single/Family)	$3,000/$6,000	$5,000/$10,000	$3,500/$7,000	$3,750/$7,500
In-network Maximum Out-of-Pocket (Single/Family)	$6,350/12,700	$6,350/12,700	$6,350/12,700	$6,350/12,700
In-network Coinsurance	50%	20%	50%	20%
Outpatient Facility Copayment	Deductible & Coinsurance	Deductible & Coinsurance	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250	Deductible & Coinsurance
Inpatient Facility Copayment	Deductible & Coinsurance	Deductible & Coinsurance.	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $250	Deductible & Coinsurance
Out-of-network Deductible (Single/Family)	N/A	N/A	N/A	$6,000/$12,000
Out-of-network Maximum Out-of-Pocket (Single/Family)	N/A	N/A	N/A	$9,000/$18,000
Out-of-network Coinsurance	N/A	N/A	N/A	40%
Prescription Drug Coverage	❑ Option 1 Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $70 copayment Mail-Order – 2.5x copay Deductible*	❑ Option 1 Tier 1 - $20 copayment Tier 2 - $40 copayment Tier 3 - $80 copayment Mail-Order - 2.5x copay Deductible*** ❑ Option 2 Tier 1 – $20 copayment Tier 2 – 30% copayment to $150 maximum Tier 3 – 45% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible***	❑ Option 1 Tier 1 – $20 copayment Tier 2 – $40 copayment Tier 3 – $80 copayment Mail-Order – 2.5x copay Deductible*** ❑ Option 2 Tier 1 – $20 copayment Tier 2 – 30% copayment to $150 maximum Tier 3 – 45% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible***	❑ Option 1 Tier 1 – $20 copayment Tier 2 – $40 copayment Tier 3 – $80 copayment Mail-Order – 2.5x copay Deductible*** ❑ Option 2 Tier 1 – $20 copayment Tier 2 – 30% copayment to $150 maximum Tier 3 – 45% copayment to a $400 maximum Mail-Order – 2.5x copay Deductible***

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

* All in-network medical and prescription services are subject to the in-network deductible. Deductibles and out-of-pocket accumulate on calendar year basis only. Referrals are required for this plan design.
** Deductible applies to Tier 2 and Tier 3 drugs.
***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 has been met.

III. PRODUCT AND PLAN DESIGNS (CONTINUED)
Bronze Plans (Continued)

Additional Benefit Options:

❑ Domestic Partner

❑ Mandated Offering – Dependent Age Extension to 29

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.

For groups seeking to purchase insurance, rather than Oxford HMO coverage, the Applicant agrees that Oxford Health Insurance, Inc. will be the only health insurer (other HMO coverage allowed) for all eligible employees who work in the state of New York 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.

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

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