

Freedom Plan® Select

HMO Laurel

HMO Laurel Select

Freedom Plan® Laurel

Freedom Plan® Laurel Select

HMO/Freedom

HMO Select

CT Blue Ribbon

HMO Deductible Plan

Connecticut Small Group Application-OHP

Oxford Health Plans (CT), Inc.

Mailing Address: 14 Central Park Drive, Hooksett, NH 03106 • www.oxfordhealth.com

I.GENERAL INFO	R	M	A	ΤI	0	N																		
Full legal name of company:																								
Address of company:																								
(Street Address City, State, Zip Code * Please -			İ								ĺ													
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Name and title of person to receive correspondence/billing	staten	nents																						
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b. Title:					 		 	 	<u> </u>	İ	<u> </u>	 							 					
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e. Fax Number:		Area Co	de]																				
Start Date of Business:	L	Area Co	de					L	L															
Cart Pate of Basillossi																								
Full legal name and address of parent company							_														_			
a. Name:																								
b. Address:																								
Full legal name & address of each subsidiary and/or affilia	ed co	mpan	y,																					
branch or satellite office whose employees are to be covered:																								
	Full legal name of company: Address of company: (Street Address City, State, Zip Code * Please - Do not use a PO Box.) Plan Administrator/Contact: a. Name and Title: b. Address: (If different from address of company) c. Phone Number: d. Fax Number: e. E-mail Address: Name and title of person to receive correspondence/billing a. Name: b. Title: c. Address: (Street Address City, State, Zip Code) d. Phone Number: e. Fax Number: Start Date of Business: Full legal name and address of each subsidiary and/or affiliat branch or satellite office whose	Full legal name of company: Address of company: (Street Address City, State, Zip Code * Please - Do not use a PO Box.) Plan Administrator/Contact: a. Name and Title: b. Address: (If different from address of company) c. Phone Number: d. Fax Number: e. E-mail Address: Name and title of person to receive correspondence/billing stater a. Name: b. Title: c. Address: (Street Address City, State, Zip Code) d. Phone Number: e. Fax Number: Fax Number: Start Date of Business: Full legal name and address of each subsidiary and/or affiliated cobranch or satellite office whose	Address of company: Citreet Address	Address of company: Address of company: (Street Address: City State, Zip Code * Please - Do not use a PD Box.) Plan Administrator/Contact: a. Name and Title: b. Address: (If different from address of company) c. Phone Number: d. Fax Number: e. E-mail Address: 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: Area Code	Address of company: Address of company: (Street Address City, State, Zip Code **Please - Do not use a PO Box.) Plan Administrator/Contact: a. Name and Title: b. Address: (If different from address of company) c. Phone Number: d. Fax Number: e. E-mail Address: a. Name: b. Title: c. Address: (Street Address: City, State, Zip Code) d. Phone Number: e. Fax Number: Area Code Area	Full legal name of company: Address of company: (Greet Address City, State, Zip Code * Please - Do not use a PO Box.) Plan Administrator/Contact: a. Name and Title: b. Address: (If different from address of company) c. Phone Number: d. Fax Number: e. E-mail Address: Name: b. Title: c. Address: (Street Address City, State, Zip Code) d. Phone Number: e. Fax Number: Full legal name and address of each subsidiary and/or affiliated company, branch or satellite office whose	Address of company: Claret Address City, State, Zip Code ** Please - De not use a PO Box.) Plan Administrator/Contact: a. Name and Title: b. Address: (If different from address of company) c. Phone Number: d. Fax Number: e. E-mail Address: Name and title of person to receive correspondence/billing statements: a. Name: b. Title: c. Address: City, State, Zip Code) d. Phone Number: e. Fax Number: 9. Fax Number: 1. Area Code 1	Address of company: Address of company: Cistret Address Dipt, State, Zip Code - Piesser - De not use a PO Box.) Plan Administrator/Contact: a. Name and Title: b. Address: (If different from address of company) c. Phone Number: d. Fax Number: e. E-mail Address: Name: b. Title: c. Address: City, State, Zip Code) d. Phone Number: e. Fax Number: Full legal name and address of parent company: Area Code	Full legal name of company: Address of company: (Street Address CDIty, State, ZD Jocia "Please - Do not use a Pile Box.) Plan Administrator/Contact: a. Name and Title: b. Address: (of different from address of company) c. Phone Number: d. Fax Number: e. E-mail Address: Name and title of person to receive correspondence/billing statements: a. Name: b. Title: c. Address: (Street Address CDIty, State, ZDity Dota') d. Phone Number: e. Fax Number: Full legal name and address of each subsidiary and/or affiliated company, branch or satellite office whose	Address of company: Address of company: (Street Address (Dity, Steet, 20 Date * Pilease - Do not use a Pile Date - Date	Full legal name of company: Address of company: (Street Address of Company: City, Sate, 2p Dode 'Please - Born tase a PID Bias) Plan Administrator/Contact: a. Name and Title: b. Address: (If different from address of company) c. Phone Number: d. Fax Number: e. E-mail Address: Name and title of person to receive correspondence/billing statements: a. Name: b. Title: c. Address: City, Sate, 2ip Dode) d. Phone Number: e. Fax Number: Full legal name and address of each subsidiary and/or affiliated company, branch or satellite office whose	Full legal name of company: Address of company: Claim Address Company Contact:	Full legal name of company: Address of company: Steep Address Company:	Full legal name of company: Address of company: Commandations Company: Commandations Company Commandations Comma	Full legal name of company: Address of company: Simult Address of company: Simult Address of company: De not use a 170 Box Dead Piezer - De not use a 170 Box Dead Piezer	Full legal name of company: Address of company: Company:	Full legal name of company: Address of company: Constructions of the process of company: Constructions of the process of company: Constructions of the process of company: Constructions of company: Constru	Full legal name of company: Address of company: Start blates of business: Address of company: Start Date of Business: Avea Core	Full legal name of company: Address of company: Characteristic Compan	Full legal name of company: Address of company: Display to the force of the force	Full legal name of company: Address of company: Close to detects Close to detects Close to detects Close to detects Close to detects Close to detect to an et 90 Bis. 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8.	Nature of business:			
9.	SIC Code filed with the State of CT:			
10.	Type of Organization:□ Corporation	☐ Partnership	☐ Proprietorship ☐ LL	C 🗖 Other
11.	Tax Identification Code or Number:			
	a. Federal I.D.			
	b. State Tax I.D.			
12.	Is your group subject to:			
	a. COBRA (20+ lives)?	☐ Yes	□ No	
	b. State Continuation (<20 lives)?	☐ Yes	□ No	
13.	Did your group employ at least 1 but no more th	an 50 employees for at le	ast 50% of your business days	
	during the preceding 12 months?	□ No		
	II.ADMINISTRAT	IVE INFO	RMATION	
The	term "coverage" refers to the benefits provided b	ny Oxford nursuant to the	Groun Certificate	
The 1.	term "coverage" refers to the benefits provided by Effective date: We request that this coverage be effective.		•	
1.	Effective date: We request that this coverage be effective	e as of the first day of	•	(Month/Year)
		e as of the first day of	th of the approved effective date.	(Month/Year)
1. 2.	Effective date: We request that this coverage be effective Anniversary date: The anniversary date will fall annually on the group health or individual coverage: Indicate below other	e as of the first day of	th of the approved effective date.	(Month/Year) If terminated, date terminated
1. 2.	Effective date: We request that this coverage be effective Anniversary date: The anniversary date will fall annually on the Other group health or individual coverage: Indicate below of the past three (3) years.	e as of the first day of the first day of the calendar moni	th of the approved effective date.	
1. 2.	Effective date: We request that this coverage be effective Anniversary date: The anniversary date will fall annually on the Other group health or individual coverage: Indicate below of the past three (3) years.	e as of the first day of the first day of the calendar moni	th of the approved effective date.	
1. 2.	Effective date: We request that this coverage be effective Anniversary date: The anniversary date will fall annually on the Other group health or individual coverage: Indicate below of the past three (3) years.	e as of the first day of the first day of the calendar moni	th of the approved effective date.	
1. 2.	Effective date: We request that this coverage be effective Anniversary date: The anniversary date will fall annually on the Other group health or individual coverage: Indicate below of the past three (3) years.	e as of the first day of the first day of the calendar moni	th of the approved effective date.	
1. 2.	Anniversary date: The anniversary date will fall annually on the Other group health or individual coverage: Indicate below off the past three (3) years. Type of coverage	e as of the first day of the first day of the calendar moni	ch of the approved effective date. e or that which has terminated within Effective date	
1. 2. 3.	Anniversary date: The anniversary date will fall annually on the Other group health or individual coverage: Indicate below off the past three (3) years. Type of coverage	e as of the first day of the first day of the calendar monitation are coverage which is still in force. Name of carrier	th of the approved effective date. e or that which has terminated within Effective date	
1. 2. 3.	Anniversary date: We request that this coverage be effective Anniversary date: The anniversary date will fall annually on the coverage below off the past three (3) years. Type of coverage Employer Contributions: Toward Employee Presented the coverage below of the past three (3) years.	e as of the first day of the first day of the calendar monitation in the coverage which is still in force. Name of carrier emium:	th of the approved effective date. e or that which has terminated within Effective date	
1. 2. 3.	Anniversary date: We request that this coverage be effective Anniversary date: The anniversary date will fall annually on the coverage below off the past three (3) years. Type of coverage Employer Contributions: Toward Employee Presented the coverage below of the past three (3) years.	e as of the first day of the first day of the calendar monit the coverage which is still in force Name of carrier emium: um: on the date the insurance provide	th of the approved effective date. e or that which has terminated within Effective date	If terminated, date terminated
1. 2. 3.	Anniversary date: We request that this coverage be effective Anniversary date: The anniversary date will fall annually on the coverage indicate below off the past three (3) years. Type of coverage Employer Contributions: Toward Employee Presented Toward Family Premises Eligibility and Termination: Each employee must be eligible of the coverage to the coverage of the coverage	e as of the first day of the first day of the calendar monit the coverage which is still in force Name of carrier emium: um: on the date the insurance provide	th of the approved effective date. e or that which has terminated within Effective date	If terminated, date terminated
1. 2. 3.	Anniversary date: We request that this coverage be effective Anniversary date: The anniversary date will fall annually on the coverage indicate below off the past three (3) years. Type of coverage Employer Contributions: Toward Employee Present Toward Family Premise for coverage on the date the Certificate becomes effective, the coverage of the coverage on the date the Certificate becomes effective, the coverage on the date the Certificate becomes effective, the coverage on the date the Certificate becomes effective, the coverage on the coverage of	e as of the first day of the first day of the calendar monitorer coverage which is still in force. Name of carrier emium: um: on the date the insurance provide the employee must wait until he/	th of the approved effective date. e or that which has terminated within Effective date	If terminated, date terminated

Defining Eligible Employees (continued)

	Retired Emp	nloyees:		Covered		Not Covered		
	The definition	n of a Retired Employee is:						
		an employee who is retire	d and	on pension b	y the en	nployer.		
		an employee who is retire	d and	on pension b	y the en	nployer and wh	no immediately	prior to the date of retirement had completed
		at least years of s	ervice	with the em	ployer.			
		an employee who is retire	d from	service by t	he emplo	oyer and who i	mmediately pri	or to the date of retirement had completed
		at least years of s	ervice	with the em	ployer.			
	b) Eligibility &	Termination: The employees	will he	come elinihle	e on the	latter of the et	fective date of	this plan or the date selected below
	*Indicate nu or months	mber of months or days, whi	chever below,	is applicable	e, in the s	space provided	below. In (i) be	elow, if there is no waiting period, insert "O" in the space provided for the number of days ar month coinciding with or next following the date on which the employee completes the
		CLASS I					1	CLASS II
Defi	nition of Class I						Defi	nition of Class II
— i)	Eligibility							Eligibility
"		the employee completes:						☐ Date on which the employee completes:
		th(s) of continuous service, o						*month(s) of continuous service, or
	* days	of continuous service.						<u>*</u> days of continuous service.
	Termination							Termination
		ation of employment					113	Date of termination of employment
ii)	Eligibility	, of the colondar month esine	idina u	uith or nout fo	llouing +	ha data an	l ii)	Eligibility On the first day of the calendar month coinciding with or next following the date on
		of the calendar month coinc loyee completes:	lulliy v	WILLI OF FIEXT 10	illowing ti	ne date on		which the employee completes:
	<u>*</u> mon	th(s) of continuous service, o						month(s) of continuous service, or
	<u>*</u> days	of continuous service.						<u>days of continuous service.</u>
	Termination							Termination
		y of the calendar month in nployment terminates.	which					On the last day of the calendar month in which employee's employment terminates.
iii)	Waiting Period for	Rehires					lii)	Waiting Period for Rehires
	Waiting Period Wa If yes, waived if re	ived for Rehires?		□ No				Waiting Period Waived for Rehires?
iv)	Waiting Period for	Full-time Employees					iv)	Waiting Period for Full-time Employees
	Waiting Period Waiv ☐ Yes ☐ N	red for existing Full-time empl Vo	oyees?					Waiting Period Waived for existing Full-time employees? ☐ Yes ☐ No
v)	Dependent Cut-Off						V)	Dependent Cut-Off
	☐ End of Semest☐ End of Calenda☐ Other (requires							☐ End of Semester ☐ End of Calendar Year ☐ Other (requires Home Office approval)

6.	Number of Total Employees the	Effective Date:		
	Full-time Employees	Part-time Employees	Retired Employees	
	Of the Total employees.	How many are active eligible full	-time employees who work in CT?	

- 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. Health Benefits covered by Medicare Part A, Part B and Part D are carved out 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
 - any child (natural, adopted, placed for adoption, or step child) of the insured or insured's spouse who is under the age of 26

Coverage for dependent children will end on the last day of the month following the month in which the child no longer meets dependent eligibilty requirements.

If a child cannot support him/herself due to mental 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 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: UnitedHealthcare Benchmark Solutions Oxford suite of products: Freedom Plan and Freedom Plan Select

1. Please select a plan type and plan number (if applicable):

☐ Freedom Plan ☐ Freedom Plan Select

(Deductibles and Out-of-pocket Accumulation Periods are on a Calendar Year basis.)

Options	Plan 4	Plan 6
Copayment	\$15	\$20
Single Deductible	\$1,000	\$1,000
Family Deductible	\$2,500	\$2,500
Coinsurance	70%	70%
Coinsurance Maximum	\$10,000	\$10,000

2.	Please select a Prescription rider and	desired coverages:					
	Pharmacy benefit: (Tier 1/ Tier	2/ Tier 3 Copayment)					
	□ \$10/\$20/\$35 □	1 \$15/\$25/\$40	□ \$15/50%	□ None			
	<u>Deductible Options:</u> For 3 tier pl	ans, the deductible applie	s to Tier 2 and Tier 3 dr	ugs. For 2 tier p	olans, the deductible is waiv	ed for generics.	
	□ None □	\$50 🗖 \$100	□ \$200				
	Contraceptives:						
	☐ Yes (Standard)	☐ No (Qualified Sta	ate Exempt Groups Only)			
	Medicare Part D 28% Subsidy - For the Medicare eligible retirees?	e Rx plan design above, do 1 Yes 🔲 No	you currently participate	or plan to partic	ipate with the 28% Governn	nent Subsidy for your	
3.	Additional Benefit Information Vision Dental Plan Premium Outpatient Physical Therapy: Generation of the Remark of the Properties of the Physical Copayment: Note the Remark of the Properties	O Visits one (Standard)	☐ Prosthetics☐ Dental Pla☐ 90 Visits (☐ \$250☐ \$35	n Enhanced Standard) ד \$500) (Standard) 🗖 S	375 🗖 \$100	
SE	Other: CTION 2: UnitedHea	SUBJECT	TO HOME OFFICE	APPROVAL			
1. Plo	HMO Laur ease select a plan type and a plan o	r el, HMO Laui design: 1 HMO Laurel Select	rel Select, and		m Plan Laurel		
	Options:		ſ	J A.	□ E.		□ F.
	Plan Type:		ŀ	IMO	НМО		НМО
	Office Copayment (PCP/Special	list):	Ş	330/\$45	\$15/\$25		\$25/\$40
	Single/Family Deductible:			N/A	N/A		N/A
	Coinsurance:		N	I/A	N/A		N/A
	Hospital Copayment: (up to \$2,	000/calendar year)	S	5500/day	\$100/continuous co	nfinement	\$250/day
	Outpatient Surgery Copayment:		Ş	3250	\$50		\$100
	Emergency Room Copayment:		Ş	3150	\$75		\$100

For prescription and additional riders please see the following page.

☐ Freedom Plan Laurel Select

(Deductibles and Out-of-pocket Accumulation Periods are on a Calendar Year basis.)

Options:	□ B.	□ C.	□ D.
Plan Type:	POS	POS	POS
Office Copayment (PCP/Specialist):	\$15/\$25	\$25/\$40	\$30/\$45
Out-of-network Deductibles:			
Single:	\$1,000	\$1,000	\$2,500
Family:	\$3,000	\$3,000	\$7,500
Out-of-network Coinsurance:	70%	70%	70%
Single Coinsurance Maximum:	\$10,000	\$15,000	\$20,000
In-network Hospital Copayment:	\$100 per admission (up to \$2,000 per calendar year)	S250 per day (up to S2,000 per calendar year)	\$500 per day (up to \$2,000 per calendar year)
Outpatient Surgery Copayment:	\$50	\$100	\$250
Emergency Room Copayment:	\$75	\$100	\$150

2. Please select a Prescription rider and desired coverages:

	Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 Copaymer	it)	
	☐ \$10/\$20/\$35 ☐ \$15/\$25/\$40 ☐ None	S 15/50%	
	Deductible options For 3 tier plans, the deduc ☐ None ☐ \$50 ☐ \$100	tible applies to Tier 2 and Tier 3 drugs. For 2 tie	er plans, the deductible is waived for generics.
	Contraceptives: See Standard) No (Qualified State Exempt Groups Only) Medicare Part D 28% Subsidy – For the Rx plan design abo		nata with the 290% Covernment Subsidy for your
	Medicare eligible retirees?	ve, ao you carrentry participate of plan to partici	pate with the 2070 dovernment outsity for your
3.	Additional Benefit Information		
	☐ Vision ☐ Dental Plan Premium Outpatient Physical Therapy Skilled Nursing Facility ☐ Other:	☐ Dental Plan Enhanced ☐ 60 Visits (Standard) ☐ 30 Visits (Standard)	☐ 90 Visits ☐ Unlimited
	SUBJ	ECT TO HOME OFFICE APPROVAL	

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<u>SECTION 3:</u> Freedom Plan, Freedom Plan Select, HMO, HMO Select, CT Blue Ribbon, and HMO Deductible Plan

1.	Please select a plan type and plan number (if app	licable):					
	Control of the Contro	Freedom Plan ods are on a Ca		S.)			
	Options: Office copayment: Single deductible: Family deductible: Coinsurance: Single coinsurance maximum:	Plan 1 \$10 \$250 \$625 80% \$5,000	☐ Plan 2 \$10 \$500 \$1,250 70% \$10,000	□ Plan 3 \$15 \$300 \$750 80% \$5,000	Plan 4 \$15 \$1,000 \$2,500 70% \$10,000	Plan 5 \$15 \$500 \$1,250 70% \$10,000	Plan 6 \$20 \$1,000 \$2,500 70% \$10,000
	□ HMO □	HMO Select					
	Options: Office copayment:	□ Plan 7 \$5	□ Plan 8 \$10	□ Plan 9 \$15	□ Plan 10 \$20		
	CT Blue Ribbon Plan Design						
2.	Office copayment Inpatient Facility copayment Skilled Nursing Facility copayment Emergency Room copayment Durable Medical Equipment copayme Prosthesis copayment Physical Therapy limit Pharmacy (includes Contraceptives)	\$500 \$25 \$400 \$400 \$30 Vis \$5 \$1,00 19/26 \$1,50	Per Admission not per Item Per Item, waived sits per prescribed 0 0 single / \$3,000	ot to exceed 50% for internal pros d course of treati			
	Please Note: If CT Blue Ribbon Plan Design was a Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 Co		lowing options ar	e not available.			
	□ \$5/\$10 □ \$5/\$15 □ \$5/\$10/\$25 □ \$5/\$15/\$: □ \$10/\$20/\$35 □ \$15/50%		□ \$7/\$2 □ \$7/\$1 □ None	0 5/\$35			
	Deductible Options: For 3 tier plans, the de ☐ None ☐ \$50	ductible applies	s to Tier 2 and Tie	er 3 drugs. For 2	2 tier plans, the d	eductible is waiv	ed for generics.
	Contraceptives: ☐ Yes (Standard) ☐ No	(Qualified State	Exempt Groups	Only)			
	Medicare Part D 28% Subsidy - For the Rx plan des Medicare eligible retirees? ☐ Yes ☐	sign above, do y ⊇ No	ou currently partic	sipate or plan to p	articipate with the	28% Governmer	it Subsidy for you
3.	Additional Benefit Information Please Note: If CT Blue Ribbon Plan Design was standard vision Dental Plan Premium Outpatient Physical Therapy: Inpatient Hospital Copayment: Emergency Room: Additional Benefit Information Plan Design was standard vision Plan Plan Premium Plan Pr	□ Pro □ De □ 90	osthetics ntal Plan Enhanco Visits (Standard) 50	ed) \$500	□ \$75 □	\$100	
	☐ Other:						
		SUBJEC	CT TO HOME	OFFICE APPE	ROVAL		_

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	HMO with deductible option	1:					
), Freedom, Non-Gated luctibles and Out-of-Pocket	Accumulation Periods a	are on a 🗖 Calendar Y	ear basis 🗖 Contrad	ot Year basis)		
	Options:		□ Plan A		□ Plan B		
	Office copayment (PCP/S	Specialist)	\$20/\$40		\$30/\$45		
	Deductible		\$1500		\$2500		
	Coinsurance		100%		100%		
	Inpatient hospital copayn	nent	Deductible & coins	urance	Deductible & coinsurance	98	
	Outpatient surgery copay	ment	Deductible & coins	urance	Deductible & coinsuranc	е	
	Emergency room copaym	nent	\$150		\$150		
Avai	lable RX Plans						J
	Options:	☐ RX Plan 1	□ RX Plan 2	RX Plan 3	☐ RX Plan 4	□ R)	K Plan 5
	Tier 1	\$7	\$7	\$15	\$10	\$15	
	Tier 2	\$20	\$15	\$25	\$20	50%	
	Tier 3	N/A	\$35	\$40	\$35	50%	
	Annual Max	None	None	None	None	None	
	Deductible Option	SO S50 Deductible applies to Tier 2 & 3 only	SO S50 Deductible applies to Tier 2 & 3 only	S0 S50 S100 S200 Deductible applies to Tier 2 & 3 only	S0 S50 S100 S200 Deductible applies to Tier 2 & 3 only		50 100
			1 No (Qualified State Exbove, do you currently p		icipate with the 28% Govern	nment Su	ubsidy for your Medicare Eligible retirees? 🗖 Yes 🗖 No
Avai	lable Riders						
Outp	/ision Dental Plan Premium Dental Plan Enhanced Jnlimited Durable Medical E atient Physical Therapy 90 ed Nursing Facility	Visits 🗖 60 Visits	(Standard) 🗖 90 Vis (Standard) 🗖 Unlimit				

SECTION 4: HMO Laurel, HMO Laurel Select, Freedom Plan Laurel, and Freedom Plan Laurel Select

1. Please select a plan type and a plan design:

HMO Laurel			□ н	NO La	urel Sel	ect

(Deductibles and Out-of-Pocket Accumulation Periods are on a Calendar Year basis.)

Options:	□ A.	□ E.	□ F.
Plan Type:	НМО	НМО	НМО
Office Copayment (PCP/Specialist):	\$30/\$45	\$15/\$25	\$25/\$40
Single/Family Deductible:	N/A	N/A	N/A
Coinsurance:	N/A	N/A	N/A
Hospital Copayment: (up to \$2,000/calendar year)	\$500/day	\$100/continuous confinement	\$250/day
Outpatient Surgery Copayment:	\$250	\$50	\$100
Emergency Room Copayment:	\$150	\$75	\$100

For prescription and additional riders please see the following page.

☐ Freedom Plan Laurel ☐ Freedom Plan Laurel Select

(Deductibles and Out-of-pocket Accumulation Periods are on a Calendar Year basis.)

Options:	□ B.	□ C.	□ D.
Plan Type:	POS	POS	POS
Office Copayment (PCP/Specialist):	\$15/\$25	\$25/\$40	\$30/\$45
Out-of-network Deductibles:			
Single:	\$1,000	\$1,000	\$2,500
Family:	\$3,000	\$3,000	\$7,500
Out of makingula Cainannana	701/	701/	701/
Out-of-network Coinsurance:	70%	70%	70%
Single Coinsurance Maximum:	\$10,000	\$15,000	\$20,000
In-network Hospital Copayment:	\$100 per admission (up to	\$250 per day (up to	\$500 per day (up to
	\$2,000 per calendar year)	\$2,000 per calendar year)	\$2,000 per calendar year)
	250	0400	2050
Outpatient Surgery Copayment:	\$50	\$100	\$250
Emergency Room Copayment:	\$75	\$100	\$150

For prescription and additional riders please see the following page.

2.	Please select a Prescription rider and desired coveraç	jes:	
	<u>Pharmacy benefit</u> : (Tier 1/ Tier 2/ Tier 3 Copa □ \$10/\$20/\$40 □ 50% (excl	yment) udes mail order) □ \$15/50%	
	□ None	400 maii 3140) — \$10,000,0	
	<u>Deductible options</u> For 3 tier plans, the d □ None □ S50	leductible applies to Tier 2 and Tier 3 drugs. For 2 tier plans, the deduc	ctible is waived for generics.
	Contraceptives: ☐ Yes (Standard) ☐ No (Qualified State Exempt Groups	Only)	
	Medicare Part D 28% Subsidy - For the Rx plan design ☐ Yes ☐ No	n above, do you currently participate or plan to participate with the 28%	o Government Subsidy for your Medicare eligible retirees?
3.	Additional Benefit Information		
	☐ Vision	- 0 .10 5:	
	Dental Plan PremiumOutpatient Physical Therapy	□ Dental Plan Enhanced □ 60 Visits (Standard) □ 90 Visits	
	Skilled Nursing Facility	30 Visits (Standard) Unlimited	
	☐ Other:		
	s	SUBJECT TO HOME OFFICE APPROVAL	
	IV.UNDERWRIT	ING GUIDELINES	
		firms that the Applicant satisfies, and if this Application is accepted by C	
	erwriting Guidelines set torth in Attachment A, nereto, and a licant hereby acknowledges that if at any time	any additional underwriting guidelines that Oxford may promulgate and v	vnich applicant is given notice of in conjunction with future renewals. In
it is	not in compliance with such underwriting guidelines or if a	any census data provided by the Applicant to Oxford, in conjunction with	
		ne date coverage by Oxford first commences, then Oxford shall have the ch amount as is determined by Oxford, in its absolute discretion, to refle	
Na	me of Applicant		_
Sig	 gnature of Authorized Officer of Applicant	Title of Officer of Applicant	 Date
	, , , , , , , , , , , , , , , , , , , ,		
	V.COBRA & EXT	TENSION OF BENEFI	TS DATA
1.	Are there any employees or dependents of employees where there are employees where there are employees or dependents of employees where there are employees or dependents of employees where there are employees or dependents of employees where the employees are employees or dependents of employees where the employees are employees or dependents of employees where the employees where the employees where the employees where the employees where the employees where the employees where the employees where the employees are employees where the empl	ho are covered under COBRA or State Continuation on your current plan?	□ Yes □ No
	If yes, identify the number of individuals		
2.	Are there any employees or dependents of employees will What is the length of the prior carrier's extension of bei		☐ Yes ☐ No

VI. 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:			
Com	ments:			

*Important Information Regarding Producer Compensation:

We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Sonuses are not reflected in the premium rate but are paid from our general administrative expenses. In general, our total bonuses are less than 10% of total producer compensation paid. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also may make payments from time to time to producers for services other than those relating to the said of policies (for example, compensation for services as a general agent or as a consultant). Producer compensation is subject to disclosure of Schedule A of the ERISA Form 5500 for customers governed by ERISA and subject to form 5500 filling requirements. We have also taken steps to ensure that producers properly disclosure their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, please go to www.orforthealth.com. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

VII. 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 acknowledges that the Effective Date of Coverage is not guaranteed and is subject to receipt by Oxford of full requirements including completed Family Health Statements for all employees and their dependents enrolling for 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, 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. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

obligation to provide coverage to the Application for an insurance policy is su	**	pted, in writing, by the Oxford Home Office. Any pers	on who includes any false or misleading i	nformation on ar
Dated at:	this	day of	20	
Applicant Name (Correct Legal Name)				
Signature of Authorized Officer of the Applican	t	X Title of Of	icer of Applicant	
Witness		Nulv Licen	sed and Annointed Producer*	

*Please note: If you are not currently appointed by Oxford in CT, you must contact Oxford's Commissions Department at 1-888-666-6844 in advance of executing this application.



Freedom Plan® Directsm
Oxford® HSA Directsm
Oxford USAsm
Oxford MyPlansm

Freedom Plan® Value Option^{sм}

Connecticut Small Group Application - OHI

Oxford Health Insurance, Inc.

Mailing Address: 14 Central Park Drive, Hooksett, NH 03106 • www.oxfordhealth.com

	I. GENERAL INFO	0 F	?	VI	A 1	0	N												
1.	Full legal name of company:																		Ī
2.	Address of company: (Street Address City, State, Zip Code *Please - Do not use a PO Box.)				<u> </u> 								<u> </u> -	<u> </u> 					
3.	Plan Administrator/ Contact:																	 	
	a. Name and Title:																		
	b. Address: (If different from address of company)							L			L	L			<u> </u>		<u></u>		
	,																		
	c. Phone Number:																		
	d. Fax Number:		Code																
	e. E-mail Address:	Area	Code																
4.	Name and title of person to receive correspondence/billin	ıg sta	teme	nts:															
	a. Name:																		
	b. Title:																		
	c. Address: (Street Address																		
	City, State, Zip Code)																		
	d. Phone Number:	Area	Code																
	e. Fax Number:	Area	Code																
5.	Full legal name & address of each subsidiary and/or affiliation	ated	com	oany	,														
	employees are to be covered:																		

	I. GENERAL II	NFORMATI	ON (continu	e d)
6.	Nature of business:			
7.	SIC Code filed with the State of CT:			
8.	Type of Organization: Corporation	☐ Partnership	☐ Proprietorship ☐	LLC
9.	Tax identification Code or Number: Federal I.D	l		
10.	Did your group employ at least 1 but no more th	an 50 employees for at least 50	% of your business days	
	during the preceding 12 months? $\ \square$	Yes		
	II. ADMINISTR <i>i</i>	ATIVE INF	0 R M A T I O N	
The	e term "coverage" means the benefits provided by C	Dxford, pursuant to the Group Cε	ertificate.	
1.	Effective date: We request that this coverage be	effective as of the first day of $\underline{\ }$		 (Month/Year)
2.	Anniversary date: The anniversary date will fall a	nnually on the first day of the c	alendar month of the approved effecti	, , , , , , , , , , , , , , , , , , ,
3.	Other group health or individual coverage: Any of Forms. Please Note: Do not cancel existing coverage until If no previous coverage, initial here	you have received acceptance o		should be indicated on the individual Member Enrollment
	Type of coverage	Name of carrier	Effective date	If terminated, date terminated
	Fundament Contributions Toward Contri	Duration	0/	
4.	Employer Contributions: Toward Emplo Toward Famil	oyee Premium: y Premium:	% %	
		,		
5.	Eligibility and Termination: Each employee must is not eligible for coverage on the date the Certif	•	•	ecomes effective with respect to him/her. If the employer le for coverage.
	a) Employee Eligibility :			
	Full-Time Employees: Please check he	ere to confirm that all permanen	nt full-time employees work a minimun	n 30 hours/week (20-29 hours, if elected by the Group).
	Also, if the minimum hours are more than	the required hours, please enter	the hours per week here	
	Retired Employees:	☐ Not Covered		
	b) Eligibility & Termination: The employee will	become eligible on the latter o	f the effective date of this plan or the	date selected below

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Indicate number of months or days, whichever is applicable, in the space provided below. In (i) below, if there is no waiting period, insert "0" in the space provided for the number of days or months of continuous service. In (ii) below, indicate whether eligibility is first day of the calendar month coinciding with or next following the date on which the employee completes the group specified length of continuous service.

	CLASS I		CLASS II
Defi	nition of Class I	Defi	nition of Class II
i)	Eligibility/Termination		Eligibility/Termination
	Date on which the employee completesdays/months (circle one) of continuous service.		☐ Date on which the employee completesdays/months (circle one) of continuous service.
	Termination will be the date of termination of employment.		Termination will be the date of termination of employment.
ii)	Eligibility/Termination	ii)	Eligibility/Termination
	On the first day of the calendar month coinciding with or next following the date on which the employee completesdays/months (circle one) of continuous service.		On the first day of the calendar month coinciding with or next following the date on which the employee completesdays/months (circle one) of continuous service.
	Termination will be on the last day of the calendar month		Termination will be on the last day of the calendar month
iii)	Waiting Period for Rehires	iii)	Waiting Period for Rehires
	Waiting Period Waived for Rehires?		Waiting Period Waived for Rehires?
	CLASS III		CLASS IV
Deti	nition of Class III	Deti	nition of Class IV
i)	Eligibility/Termination	i)	Eligibility/Termination
	Date on which the employee completesdays/months (circle one) of continuous service.		Date on which the employee completesdays/months (circle one) of continuous service.
	Termination will be the date of termination of employment.		Termination will be the date of termination of employment.
ii)	Eligibility/Termination	ii)	Eligibility/Termination
	On the first day of the calendar month coinciding with or next following the date on which the employee completesdays/months (circle one) of continuous service.		On the first day of the calendar month coinciding with or next following the date on which the employee completes
	Termination will be on the last day of the calendar month		Termination will be on the last day of the calendar month

	CLASS V		CLASS VI
Def	inition of Class V	Def	inition of Class VI
_ i)	Eligibility/Termination	i)	Eligibility/Termination
	Date on which the employee completesdays/months (circle one) of continuous service.		Date on which the employee completesdays/months (circle one) of continuous service.
	Termination will be the date of termination of employment.		Termination will be the date of termination of employment.
ii)	Eligibility/Termination	ii)	Eligibility/Termination
	On the first day of the calendar month coinciding with or next following the date on which the employee completesdays/months (circle one) of continuous service.		On the first day of the calendar month coinciding with or next following the date on which the employee completesdays/months (circle one) of continuous service.
	Termination will be on the last day of the calendar month		Termination will be on the last day of the calendar month
		•	
6.	Number of Total Employees the Effective Date:		
	Full-time employees Part-time employees Retired employees: Were 51% or more active eligible full-time employe	-	

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- 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.
- Integration with Medicare Benefits: Health benefits will be coordinated with Medicare benefits for any employee over the age of 65 who is not actively at work. Health benefits covered by Medicare Part A, Part B and Part D are carved out 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
 - any child (natural, adopted, placed for adoption, or step child) of the insured or insured's spouse who is under the age of 26

Coverage for dependent children will end on the last day of the month following the month in which the child no longer meets dependent eligibility requirements.

If a child cannot support him/herself due to mental 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 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.

III. PRODUCT / PLAN DESIGN

SECTION 1: UnitedHealthcare Benchmark Solutions Oxford suite of products: Freedom Plan Direct

1. Please select a plan type:

. Please select a pla	ın type:					
Options	□ Plan 1	☐ Plan 2	□ Plan 3	□ Plan 7	☐ Plan 8	□ Plan 9
Copayment	\$15 PCP/ \$25 Specialist	\$25 PCP/ \$40 Specialist	\$25 PCP/ \$40 Specialist	\$15 PCP/ \$25 Specialist	\$25 PCP/ \$40 Specialist	\$25 PCP/ \$40 Specialist
Single Deductible	\$500/ \$1,000	\$500/ \$1,000	\$1,000/ \$2,000	\$1,000/ \$2,000	\$500/ \$1,000	\$1,000/ \$2,000
Family Deductible	\$1,000/ \$2,000	\$1,000/ \$2,000	\$2,000 <i>/</i> \$4,000	\$2,000/ \$4,000	\$1,000 <i>/</i> \$2,000	\$2,000/ \$4,000
Coinsurance	90%/70%	80%/60%	80%/60%	100%/70%	100%/70%	100%/70%
Options	☐ Plan 10	☐ Plan 11	□ Plan 12			
Copayment	\$30 PCP/ \$45 Specialist	\$30 PCP/ \$45 Specialist	\$30 PCP/ \$45 Specialist			
Single Deductible	\$1,500 \$2,500	\$2,500 \$2,500	\$5,000 \$5,000			
Family Deductible	\$3,000 \$5,000	\$5,000 \$5,000	\$10,000 \$10,000			
Coinsurance	100%/70%	100%/70%	100%/70%			
	escription rider and des	sired coverages:		act year basis.		
□ None □	\$50 🔲 \$100 6 Subsidy - For the prescr	□ \$200	and Tier 3 drugs. On two tie o you currently participate			Subsidy for your Medicare
Durable Medical Equi Outpatient Physical T	ipment: \$1,500 per Therapy: 60 Visits (r calendar year (Standard) Standard) 🔲 90 V	☐ Unlimite lisits	d		
Dental: 🗖 Premi Skilled Nursing Facili		Standard) 🖵 Unlir	mited			

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SECTION 2: UnitedHealthcare Benchmark Solutions Oxford suite of products: Oxford HSA Direct

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

1. Please select a plan number:

No referrals are required for t	nese plan designs.					
n-Network/Out-of-Network	Plan 1	Plan 2	☐ Plan 3	☐ Plan 4	Plan 5	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 Out-of-pocket Maximum	\$3,250	\$3,000	\$3,850	\$1,250	\$2,000	\$2,850
, , , , ,	•		ce the in-network de	eductible has been	satisfied): **	
, , , , ,	rescription rider and d 5/\$25/\$40 🔲 \$15/		ce the in-network de	eductible has been	satisfied): **	
\$10/\$20/\$35 \$1	5/\$25/\$40 \ \$15/			eductible has been	satisfied): **	
\$10/\$20/\$35 \$1	5/\$25/\$40	/50% (Qualified State Exempt e subject to the in-network n inception. Out-of-networ	Groups Only) deductible. Once the de k benefits are accumulat	ductible has been satisfi ed separately. No indivi	ed, the applicable medica	
\$10/\$20/\$35 \$1 Contraceptives \$Ye **NOTE: All in-network medical copayment will apply based or	5/\$25/\$40 \$15/ s (Standard) No (and pharmacy services are to the option selected at plar of-pocket until the entire fa	/50% (Qualified State Exempt exubject to the in-network in inception. Out-of-network inity deductible or maximu	Groups Only) deductible. Once the de k benefits are accumulat m out-of-pocket have be	ductible has been satisfi ed separately. No indivi en met.	ed, the applicable medica dual on a multiple person	contract may satisfy the
\$10/\$20/\$35 \$1 Contraceptives Ye **NOTE: All in-network medical copayment will apply based or deductible and maximum out- Medicare Part D 28% Subsidy	5/\$25/\$40	/50% (Qualified State Exempt exubject to the in-network in inception. Out-of-network inity deductible or maximu	Groups Only) deductible. Once the de k benefits are accumulat m out-of-pocket have be	ductible has been satisfi ed separately. No indivi en met.	ed, the applicable medica dual on a multiple person	contract may satisfy the
□ \$10/\$20/\$35 □ \$1 Contraceptives □ Ye **NOTE: All in-network medical copayment will apply based or deductible and maximum out- Medicare Part D 28% Subsidy eligible retirees? □ Yes Additional Benefit Information Dental: □ Premium	5/\$25/\$40	/50% (Qualified State Exempt exubject to the in-network in inception. Out-of-network inity deductible or maximu	Groups Only) deductible. Once the de k benefits are accumulat m out-of-pocket have be	ductible has been satisfi ed separately. No indivi en met.	ed, the applicable medica dual on a multiple person	contract may satisfy the
\$10/\$20/\$35 \$1 Contraceptives Ye **NOTE: All in-network medical copayment will apply based or deductible and maximum out- Medicare Part D 28% Subsidy eligible retirees? Yes Additional Benefit Informa	5/\$25/\$40	/50% (Qualified State Exempt e subject to the in-network in inception. Out-of-networ amily deductible or maximulan design above, do you	Groups Only) deductible. Once the de k benefits are accumulat m out-of-pocket have be	ductible has been satisfi ed separately. No indivi en met.	ed, the applicable medica dual on a multiple person	contract may satisfy the

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SECTION 3a: UnitedHealthcare Benchmark Solutions Oxford suite of products: Oxford USA

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

1. Please select a plan number (based on the in-area Oxford HSA Direct)

No referrals are required for t	hese plan designs.					
In-Network/Out-of-Network	☐ Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	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 Dut-of-pocket Maximum	\$3,250	\$3,000	\$3,850	\$1,250	\$2,000	\$2,850
. Please select (required) p □ \$10/\$20/\$35 \$15. Contraceptives □ Yes (Sta	/\$25/\$40	\$15/50% ed State Exempt Groups				
**NOTE: All in-network medical prescription drug copayment	al and pharmacy services are	e subject to the in-network	deductible. Once the de			coinsurance and
Medicare Part D 28% Subsideligible retirees? ☐ Yes	y – For the prescription p No	olan design above, do yo	u currently participate	or plan to participate	with the 28% Governn	nent Subsidy for your
Additional Benefit Information Vision Unlimited DME (Standard Unlimited Skilled Nursing 90 Visits per condition/lif	\$1,500 per calendar yea (Standard 30 days per ca	alendar year)	<i>r</i> isits per condition/life	time)		

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SECTION 3b: UnitedHealthcare Benchmark Solutions Oxford suite of products: Oxford USA

1. Please select a plan number (Based on the in-area Freedom Plan POS):

Options	☐ Plan 4	☐ Plan 6	
Copayment	\$15	\$20	
Single Deductible	\$1,000	\$1,000	
Family Deductible	\$2,500	\$2,500	
Coinsurance	70%	70%	
Coinsurance Maximum	\$10,000	\$10,000	

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

2. Please select a prescription rider and desired coverages:

□ None	1 \$10/\$20/\$35	□ \$15/\$25/\$40	15/50%	
Deductible opt	• •	he deductible applies	to Tier 2 and Tier 3 drugs. On two tier p	lans, the deductible is waived for generics.
Contraceptives	s: 🖵 Yes (Stan	ndard) 🔲 No (Qua	alified State Exempt Groups Only)	
Medicare Part eligible retiree		rescription plan desiç	gn above, do you currently participate or	plan to participate with the 28% Government Subsidy for your Medicare
Additional Bo	enefit Information:			
☐ Vision	☐ None (Standard) Hos	spital copayment	☐ \$250 Hospital copayment	☐ \$500 Hospital copayment
☐ Other:				
_		SUBJECT TO HOME	OFFICE APPROVAL	

Please Note: Dental plans are not available for Oxford USA.

3.

1.

2.

3.

SECTION 3c: UnitedHealthcare Benchmark Solutions Oxford suite of products: Oxford USA

Out-of-Network Deductibles: Single: Family: Samily: Single Coinsurance: Single Coinsurance Maximum: In-Network Hospital Copayment: Single Coinsurance Maximum: Single Coi	000 % ,000 0 per admission to \$2,000 per endar year)	\$25/\$40 \$1,000 \$3,000 70% \$15,000 \$250 per day (up to \$2,000 per calendar year) \$100 \$100	\$30/\$45 \$2,500 \$7,500 70% \$20,000 \$500 per day (up to \$2,000 per calendar year) \$250 \$150
Single: \$1, Family: \$3, Out-of-Network Coinsurance: 709 Single Coinsurance Maximum: \$10 In-Network Hospital Copayment: \$10 Outpatient Surgery Copayment: \$50 Emergency Room Copayment: \$75 Eselect a prescription rider and desired coverages: Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 copayment)	000 % ,000 0 per admission to \$2,000 per endar year)	\$3,000 70% \$15,000 \$250 per day (up to \$2,000 per calendar year) \$100	\$7,500 70% \$20,000 \$500 per day (up to \$2,000 per calendar year) \$250
Family: \$3, Out-of-Network Coinsurance: 709 Single Coinsurance Maximum: \$10 In-Network Hospital Copayment: \$10 Outpatient Surgery Copayment: \$50 Emergency Room Copayment: \$75 Esselect a prescription rider and desired coverages: Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 copayment)	000 % ,000 0 per admission to \$2,000 per endar year)	\$3,000 70% \$15,000 \$250 per day (up to \$2,000 per calendar year) \$100	\$7,500 70% \$20,000 \$500 per day (up to \$2,000 per calendar year) \$250
Out-of-Network Coinsurance: 709 Single Coinsurance Maximum: \$10 In-Network Hospital Copayment: \$10 Outpatient Surgery Copayment: \$50 Emergency Room Copayment: \$75 Eselect a prescription rider and desired coverages: Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 copayment)	6 ,000 O per admission to \$2,000 per endar year)	70% \$15,000 \$250 per day (up to \$2,000 per calendar year) \$100	70% \$20,000 \$500 per day (up to \$2,000 per calendar year) \$250
Single Coinsurance Maximum: \$10 In-Network Hospital Copayment: \$10 (up cale Outpatient Surgery Copayment: \$50 Emergency Room Copayment: \$75 e select a prescription rider and desired coverages: Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 copayment)	,000 O per admission to \$2,000 per endar year)	\$15,000 \$250 per day (up to \$2,000 per calendar year) \$100	\$20,000 \$500 per day (up to \$2,000 per calendar year) \$250
In-Network Hospital Copayment: (up calc Outpatient Surgery Copayment: Emergency Room Copayment: **Step Select a prescription rider and desired coverages: Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 copayment)	O per admission to \$2,000 per endar year)	\$250 per day (up to \$2,000 per calendar year)	\$500 per day (up to \$2,000 per calendar year)
Outpatient Surgery Copayment: \$50 Emergency Room Copayment: \$75 Eselect a prescription rider and desired coverages: Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 copayment)	to \$2,000 per endar year)	per calendar year) \$100	per calendar year) \$250
Outpatient Surgery Copayment: \$50 Emergency Room Copayment: \$75 e select a prescription rider and desired coverages: Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 copayment)	endar year) J	\$100	\$250
Outpatient Surgery Copayment: \$50 Emergency Room Copayment: \$75 e select a prescription rider and desired coverages: Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 copayment))	·	· ·
Emergency Room Copayment: \$75 e select a prescription rider and desired coverages: Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 copayment)		·	· ·
e select a prescription rider and desired coverages: Pharmacy benefit: (Tier 1/ Tier 2/ Tier 3 copayment)	i	\$100	\$150
<u>Pharmacy benefit</u> : (Tier 1/ Tier 2/ Tier 3 copayment)			
generics.	□ \$200		
Medicare Part D 28% Subsidy – For the prescription plan d Government Subsidy for your Medicare eligible retirees?	esign above, do you cu Yes No	ırrently participate or plan to participat	te with the 28%
onal Benefit Information:			
□ Vision			
Outpatient Physical Therapy 🗖 60 Visits	☐ 90 Visits (Standar	rd)	
	Unlimited		
Government Subsidy for your Medicare eligible retirees?	☐ Yes ☐ No		
Outpatient Physical Therapy 🗖 60 Visits		rd)	

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III. PRODUCT / PLAN DESIGN

SECTION 3d: UnitedHealthcare Benchmark Solutions Oxford suite of products: Oxford USA

1. Please select a plan type (based on the in-area Freedom Plan Direct):

	3,70 (
Options	☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 7	☐ Plan 8	□ Plan 9			
Copayment	\$15 PCP/ \$25 Specialist	\$25 PCP/ \$40 Specialist	\$25 PCP/ \$40 Specialist	\$15 PCP/ \$25 Specialist	\$25 PCP/ \$40 Specialist	\$25 PCP/ \$40 Specialist			
Single Deductible	\$500/ \$1,000	\$500 <i>/</i> \$1,000	\$1,000 <i>/</i> \$2,000	\$1,000 <i>/</i> \$2,000	\$500/ \$1,000	\$1,000 <i>/</i> \$2,000			
Family Deductible	\$1,000/ \$2,000	\$1,000/ \$2,000	\$2,000 <i>/</i> \$4,000	\$2,000 <i>/</i> \$4,000	\$1,000/ \$2,000	\$2,000 <i>/</i> \$4,000			
Coinsurance	90%/70%	80%/60%	80%/60%	100%/70%	100%/70%	100%/70%			
Options	☐ Plan 10	☐ Plan 11	☐ Plan 12						
Copayment \$30 PCP/ \$30 PCP/ \$30 PCP/ \$45 Specialist \$45 Specialist \$45 Specialist									
Single Deductible \$1,500 \$2,500 \$5,000 \$2,500 \$2,500 \$5,000									
Family Deductible	\$3,000 \$5,000	\$5,000 \$5,000	\$10,000 \$10,000						
Coinsurance	100%/70%	100%/70%	100%/70%						
	rescription rider and des	•	lar year basis 🖵 contr 🖵 \$15/50%	act year basis.					
Contraceptives 🖵	Yes (Standard) 🔲 No	(Qualified State Exempt Gro	ups Only)						
□ None □ Medicare Part D 28	<u>Deductible options:</u> On three tier plans, the deductible applies to Tier 2 and Tier 3 drugs. On two tier plans, the deductible is waived for generics.								
Additional Benefit Durable Medical Equ Outpatient Physical Vision	uipment: \$1,500 per Therapy: 60 Visits (·		d					
Skilled Nursing Faci	lity: 🔲 30 Visits (Standard) 🖵 Unlim	ileu						

SECTION 4: Freedom Plan Direct

1. Please select a plan number:

No referrals are required for these plan designs.

Options	☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4	☐ Plan 5	☐ Plan 6	☐ Plan 7	☐ Plan 8	☐ Plan 9
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
Single Deductible	\$500/ \$1,000	\$500/ \$1,000	\$1,000/ \$2,000	\$500/ \$1,000	\$1,000/ \$2,000	\$2,000/ \$2,000	\$1,000/ \$2,000	\$500/ \$1,000	\$1,000/ \$2,000
Family Deductible	\$1,000/ \$2,000	\$1,000/ \$2,000	\$2,000/ \$4,000	\$1,000/ \$2,000	\$2,000/ \$4,000	\$4,000/ \$4,000	\$2,000/ \$4,000	\$1,000/ \$2,000	\$2,000/ \$4,000
Coinsurance	90%/70%	80%/60%	80%/60%	90%/70%	80%/60%	90%/70%	100%/70%	100%/70%	100%/70%

Ded	luctibles and out-of-pocket a	ccumulation periods are on	a 🖵 calendar year ba	ısis 🖵 contract year basis.
2.	Please select a prescription	n rider and desired coverage	es:	
	■ Waived coverage			
	□ \$7/\$20 □ \$7/\$15/\$	35 🔲 \$10/\$20/\$35	\$15/50%	
	Contraceptives 🖵 Yes (Stand	lard) 🔲 No (Qualified State	Exempt Groups Only)	
		ier plans, the deductible applie	s to Tier 2 and Tier 3 dr	ugs. On two tier plans, the deductible is waived for generics.
	□ None □ \$50			
	•		gn above, do you curren	tly participate or plan to participate with the 28% Government Subsidy for your Medicare
	eligible retirees? Yes	l No		
3.	Additional Benefit Informati	ion:		
	Durable Medical Equipment:	☐ \$1,500 per calendar year	(Standard)	☐ Unlimited
	Outpatient Physical Therapy:	60 Visits (Standard)	90 Visits	
	■ Vision			
	Dental: Premium	■ Enhanced		
	Skilled Nursing Facility:	■ 30 Visits (Standard)	Unlimited	

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PRODUCT DESIGN (continued)

SECTION 5: Oxford HSA Direct

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

Please select a plan number:

In-Network/Out-of-Network	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	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 Out-of-pocket Maximum	\$3,250	\$3,000	\$3,850	\$1,250	\$2,000	\$2,850

Please select (required) prescription rider and desired coverages (once the in-network deductible has been satisfied.

\$7/\$15/\$35

\$15/\$25/\$40

\$15/50%

☐ No (Qualified State Exempt Groups Only)

**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.

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 ☐ Yes eligible retirees? ☐ No

Additional Benefit Information:

☐ Vision

☐ Unlimited DME (Standard \$1,500 per calendar year)

☐ Unlimited Skilled Nursing (Standard 30 days per calendar year)

☐ 90 Visits per condition/lifetime Outpatient Physical Therapy (Standard 60 visits per condition/lifetime)

SECTION 6: Oxford MyPlan

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

1. Please select a plan number:

No referrals are required fo	tilese piali desiglis		
In-Network/Out-of-Network	☐ Plan 1	Plan 2	☐ Plan 3
Office Visit Copayment	\$25/\$40	N/A	N/A
Single Deductible	\$1,000/\$2,000	\$1,000/\$2,000	\$2,000/\$2,000
Family Deductible	\$2,000/\$4,000	\$2,000/\$4,000	\$4,000/\$4,000
Coinsurance	80%/60%	80%/60%	90%/70%

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

2. Please a select prescription rider and desired coverages:

Waived	coverage
--------	----------

- □ \$7/\$15/\$35 Mandatory \$50 Rx Deductible
- **□** \$10/\$20/\$35 Mandatory \$50 Rx Deductible

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

3. Additional Benefit Information:

 Enhanced

Vision

III. PRODUCT / PLAN DESIGN

SECTION 7: Freedom Plan Value Option

1. Please select a plan type:

<u>In-network</u>	☐ Plan A	☐ Plan B	☐ Plan C	☐ Plan D	☐ Plan E	☐ Plan F	☐ Plan G	☐ Plan H
PCP/Specialist Copayment	\$ 15	\$20	\$20	\$20	\$15/\$30	\$20/\$40	\$20/\$40	\$20/\$40
Single Deductible	\$1,500	\$2,500	\$3,500	\$5,000	\$1,500	\$2,500	\$3,500	\$5,000
Family Deductible	\$3,000	\$5,000	\$7,000	\$10,000	\$3,000	\$5,000	\$7,000	\$10,000
Coinsurance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Maximum	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Out-of-network Copayment	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Single Deductible	\$3,000	\$5,000	\$7,000	\$10,000	\$3,000	\$5,000	\$7,000	\$10,000
Family Deductible	\$6,000	\$10,000	\$14,000	\$20,000	\$6,000	\$10,000	\$14,000	\$20,000
Coinsurance	70%	70%	70%	70%	70%	70%	70%	70%
Coinsurance Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

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

2. Please select optional prescription drug coverage:

	Copayment Tier 1 Drugs					
	Copayment Tier 2 Drugs					
	Copayment Tier 3 Drugs					
	Prescription Deductible					
	Waive prescription option					
	Contraceptives \square Yes (Stand	ard) 🔲 No (Qualified State E	Exempt Groups Only)			
	Medicare Part D 28% Subsidy -	For the prescription plan design	above, do you currently	participate or plan to partici	pate with the 28% Government Subsid	dy for your Medicare eligi-
	ble retirees? \square Yes \square	No				
3.	Additional Benefit Informati	on:				
	☐ Vision					
	Outpatient Physical Therapy	☐ 60 Visits (Standard)	90 Visits			
	Skilled Nursing Facility	30 Visits (Standard)) 🗖 Unlimited			
	Emergency Room Copayment	□ \$75 (Standard)	□ \$100	 \$150		
	☐ Other:					
		SUBJECT TO HOME	OFFICE APPROVAL	-	_	

Please Note: Dental plans are not available for Freedom Plan Value Option plans.

DESIGN (continued) PLAN

SECTION 8a: Oxford USA

Please select a plan number (Based on the in-area Freedom Plan POS):

Options	☐ Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
Copayment	\$10	\$10	\$15	\$15	\$15	\$20
Single Deductible	\$250	\$500	\$300	\$1,000	\$500	\$1,000
Family Deductible	\$625	\$1,250	\$750	\$2,500	\$1,250	\$2,500
Coinsurance	80%	70%	80%	70%	70%	70%
Coinsurance Maximum	\$5,000	\$10,000	\$5,000	\$10,000	\$10,000	\$10,000

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

2.	Please select a	prescription	rider	and	desired	coverages:	

i iouoo ooioot u procomption	muon uma accinca coveragee.	
\$5/\$10	 \$5/\$15/\$35	\$15/50%
\$5/\$15	 \$7/\$15/\$35	
\$7/\$20	 \$10/\$20/\$35	
\$5/\$10/\$25	☐ None	
Deductible options: On three ti □ None □ \$50	ier plans, the deductible applies to	Tier 2 and Tier 3 drugs. On two tier plans, the deductible is waived for generics.
Contraceptives:	Yes (Standard) 🔲 No (Qual	ified State Exempt Groups Only)
Medicare Part D 28% Subsidy eligible retirees? ☐ Yes	- For the prescription plan design □ No	above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare
Additional Benefit Informati	on:	
☐ Vision		

□ \$500 Hospital copayment

□ \$250 Hospital copayment

SUBJECT TO HOME OFFICE APPROVAL

Please Note: Dental plans are not available for Oxford USA.

☐ None (Standard) Hospital copayment

3.

🗖 Other: ___

SECTION 8b: Oxford USA - Con't.

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

 \square 90 Visits per condition/lifetime Outpatient Physical Therapy (Standard 60 visits per condition/lifetime)

1. Please select a plan number: (based on the in-area Oxford HSA Direct)

No referrals are required for th	nese plan designs.					
In-Network/Out-of-Network	☐ Plan 1	Plan 2	☐ Plan 3	☐ Plan 4	Plan 5	☐ 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 Out-of-pocket Maximum	\$3,250	\$3,000	\$3,850	\$1,250	\$2,000	\$2,850
2. Please select (required) pl \$7/\$15/\$35 \$1 Contraceptives \$\Pi\$ Yes (Star	5/\$25/\$40	lesired coverages (on 5/50% ed State Exempt Groups		eductible nas been	sausnea): ***	
**NOTE: All in-network medical drug copayment will apply base					ed, the applicable medica	l coinsurance and prescription
Medicare Part D 28% Subsidy eligible retirees? ☐ Yes	y – For the prescription p □ No	olan design above, do yo	u currently participate	or plan to participate	with the 28% Governm	nent Subsidy for your Medic
3. Additional Benefit Informa Vision Unlimited DME (Standard Unlimited Skilled Nursing	\$1,500 per calendar yea	•				

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SECTION 8c: Oxford USA - Con't.

Options:	☐ Plan 1	☐ Plan 2	☐ Plan 3
Office Copayment (PCP/Specialist): Out-of-Network Deductibles:	\$15/\$25	\$25/\$40	\$30/\$45
Single:	\$1,000	\$1,000	\$2,500
Family:	\$3,000	\$3,000	\$7,500
Out-of-Network Coinsurance:	70%	70%	70%
Single Coinsurance Maximum:	\$10,000	\$15,000	\$20,000
In-Network Hospital Copayment:	\$100 per admission	\$250 per day (up to \$2,000	\$500 per day (up to \$2,000
	(up to \$2,000 per calendar year)	per calendar year)	per calendar year)
Outpatient Surgery Copayment:	\$50	\$100	\$250
Emergency Room Copayment:	\$75	\$100	\$150
\$10/\$20/\$40 \$50%	□ \$15/50% □ Y	<i>N</i> aived	
Deductible options On three tier plans, the degenerics. ☐ None ☐ \$50 Contraceptives: ☐ Yes (Standard) ☐ No (Qualified State Exempt Groups Only) Medicare Part D 28% Subsidy – For the Rx pla Government Subsidy for your Medicare eligible	eductible applies to Tier 2 and Tier an	3 drugs. On two tier plans, the deductil	
Deductible options On three tier plans, the degenerics. None \$50 Contraceptives: Yes (Standard) No (Qualified State Exempt Groups Only) Medicare Part D 28% Subsidy – For the Rx place Government Subsidy for your Medicare eligible tional Benefit Information:	eductible applies to Tier 2 and Tier an	3 drugs. On two tier plans, the deductil	
Deductible options On three tier plans, the degenerics. None \$50 Contraceptives: Yes (Standard) No (Qualified State Exempt Groups Only) Medicare Part D 28% Subsidy – For the Rx pla Government Subsidy for your Medicare eligible tional Benefit Information: Vision Outpatient Physical Therapy 60 Visi	eductible applies to Tier 2 and Tier an	3 drugs. On two tier plans, the deductil participate or plan to participate with th isits (Standard)	
Deductible options On three tier plans, the degenerics. None \$50 Contraceptives: Yes (Standard) No (Qualified State Exempt Groups Only) Medicare Part D 28% Subsidy – For the Rx pla Government Subsidy for your Medicare eligible tional Benefit Information: Vision Outpatient Physical Therapy 60 Visi	an design above, do you currently per retirees?	3 drugs. On two tier plans, the deductil participate or plan to participate with th isits (Standard) nited	
Deductible options On three tier plans, the degenerics. None \$50 Contraceptives: Yes (Standard) No (Qualified State Exempt Groups Only) Medicare Part D 28% Subsidy – For the Rx place of the subsidy for your Medicare eligible tional Benefit Information: Vision Outpatient Physical Therapy 60 Vision Skilled Nursing Facility 0 30 Vision Other:	an design above, do you currently per retirees?	3 drugs. On two tier plans, the deductil participate or plan to participate with th isits (Standard) nited	
Deductible options On three tier plans, the degenerics.	an design above, do you currently per retirees? Yes No sits 90 V	3 drugs. On two tier plans, the deductil participate or plan to participate with th isits (Standard) nited	e 28%
Deductible options On three tier plans, the degenerics.	an design above, do you currently per retirees? Yes No sits 90 V	3 drugs. On two tier plans, the deductil participate or plan to participate with th isits (Standard) nited	
Deductible options On three tier plans, the degenerics.	an design above, do you currently per retirees? Yes No sits 90 V	3 drugs. On two tier plans, the deductil participate or plan to participate with th isits (Standard) nited	e 28%
Deductible options On three tier plans, the degenerics.	an design above, do you currently per retirees?	3 drugs. On two tier plans, the deductil participate or plan to participate with th isits (Standard) nited	e 28%

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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:			
Cor	nments:			

*Important Information Regarding Producer Compensation:

We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. In general, our total bonuses are less than 10% of total producer compensation paid. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also may make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant). Producer compensation is subject to disclosure of Schedule A of the ERISA Form 5500 for customers governed by ERISA and subject to form 5500 filing requirements. We have also taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, please go to www.oxfordhealth.com. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

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 insurance 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 immediate	ly and shall (check one onl	y):
	Remain in place until it	t is expressly revoked by m	e 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.

I 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. 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		
Signature of Authorized Officer of Company	Title of Officer of Company	Date

VIII. 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 acknowledges that the Effective Date of Coverage is not guaranteed and is subject to receipt by Oxford of full requirements including completed Family Health Statements for all employees and their dependents enrolling for 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, 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.

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

X		
Signature of Authorized Officer of the Applicant	Title of Officer of Applicant	Date
X		
Duly Licensed and Annointed Producer*		Date

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^{*}Please note: If you are not currently appointed by Oxford in CT, you must contact Oxford's Commissions Department at 1-888-666-6844 in advance of executing this application.

Connecticut Member Enrollment Form - OHP

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,
EACH FIELD MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

Use only black or blue 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)

Complete the "Family Health Statement," if required

Attach disability paperwork, if applicable

Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation (SC)

In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you may be at risk.

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

CT-10-255 4207 REV 9

Connecticut Member Enrollment Form – OHP

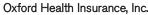


MAILING ADDRESS: P. O. Box 7085, Bridgeport, CT 06601 • 1-800-444-6222 • www.oxfordhealth.com

Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY

A. Group Information (To be com	pleted by the employer)					
Group Number Group Name	protect by the employer,	Plan CSP	Billing Group	Date of Hire	Effective Date	Occupation
·				/ /	/ /	'
☐ Actively at Work - Hours Per Week ☐ On Leave of Absence ☐ Union E		COBRA/SC C	Qualifying Event	Event Date / /	Employer Signature	Date / /
B. Applicant Details (To be complete	eted by the employee)	Employee	:/Subscriber	Spouse	Child	Child
Social Security Number:						
Last Name:						
First Name, Middle Initial:						
Date of Birth: (MM/DD/YYYY)		/	1	1 1	1 1	/ /
Gender and Disability Status: (Check a	appropriate boxes)	□M □F	/ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Num PCP Name: (If an existing patient of P			☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:				☐ Civil Union ☐ Domestic Partner ☐ Actively Working		
C. Coordination of Benefits		Employee	/Subscriber	Spouse	Child	Child
Medicare Coverage	Check appropriate box and list effective date:	☐ Part A ☐ Part B ☐ Part D	/ / / / / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all Effective Date: / /	Policy Number: Carrier: Policyholder: Group Number:		BIN:	BIN:	BIN:	BIN:
Medical ☐ Same for all	Policy Number: Carrier: Policyholder: Effective Date:		PCN:	PCN: / /	PCN: / /	PCN:
I authorize deductions from my earnings for any required contributrue to the best of my knowledge. Any person who knowingly and ulent insurance act, which is a crime and subjects such person to specialist physician with an authorized referral from the primary cathe Certificate.	with intent to defraud any insurance com- criminal and civil penalties. I understand	pany or other person files ar d that, in order to receive HI	n application for insurance or a MO benefits, I and any enrolle	statement of claim containing any materially false informat ed dependents must seek care through our Oxford affiliat	on concerning any fact material thereto commits a fraud- ed primary care physician or through an Oxford affiliated	
Employee's Address (Apt #)				Employee's Signature	Date	
City	State	ZIP Code		X	1 1	
T						

Connecticut Member Enrollment Form - OHI



CT-10-254

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



5123 REV 9

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,
EACH FIELD MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

🖎 Use only black or blue 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)

Complete the "Family Health Statement," if required

Attach disability paperwork, if applicable

Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation (SC)

In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you may be at risk.

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

Connecticut Member Enrollment Form - OHI



Oxford Health Insurance, Inc.

MAILING ADDRESS: P. O. Box 7085, Bridgeport, CT 06601 • 1-800-444-6222 • www.oxfordhealth.com Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY

A. Group Information (To be com	pleted by the employe	er)				
Group Number Group Name		Plan CSP	Billing Group	Date of Hire	Effective Date	Occupation
				/ /	1 1	
☐ Actively at Work - Hours Per Week _	Retired	COBRA/SC C	Qualifying Event	Event Date	Employer Signature	Date
☐ On Leave of Absence ☐ Union Em	nployee \square Disabled			1 1	X	/ /
B. Applicant Details (To be comple	eted by the employee)	Employee	e/Subscriber	Spouse	Child	Child
Social Security Number:						
Last Name:						
First Name, Middle Initial:						
Date of Birth: (MM/DD/YYYY)		1	1	1 1	1 1	/ /
Gender and Disability Status: (Check a	ppropriate boxes)	□M □F	/ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Numb PCP Name: (If an existing patient of PC			☐ Yes	☐ Ye	s Yes	☐ Yes
Check all that apply:				☐ Civil Union ☐ Domestic Partner ☐ Actively Working		
C. Coordination of Benefits		Employee	e/Subscriber	Spouse	Child	Child
Medicare Coverage	Check appropriate box and list effective date:	☐ Part A ☐ Part B ☐ Part D	/ / / / / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	□ Part A / / □ Part B / / □ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy	Policy Number:					
☐ Same for all	Carrier:					
Effective Date: / /	Policyholder: Group Number:		BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical	Policy Number: Carrier:		T OIN.	TON	1014.	TON.
☐ Same for all	Policyholder: Effective Date:	/	/	1 1	1 1	1 1
I understand that my enrollments and benefits are in according through our Oxford affiliated primary care physician or through conditions outlined in the Certificate. Any personal conditions outlined in the Certificate.	ough an Oxford affiliated specialist	physician with an auth	orized referral from primar	ry care physician if required. Covered services v	vill be treated as out-of-network benefits under the	
Employee's Address (Apt #)				Employee's Signature	Date	
City	State	ZIP Code		X	1 1	

CT-10-254 5123 REV 9



Connecticut Legislation on Premium Payments for Terminated Employees

We want you to be aware of important State of Connecticut legislation regarding health insurance premium payments for terminated employees.

Effective October 1, 2009, Connecticut Public Act No. 09-126 provides employers (with fully insured health plans) an election to terminate an employee's medical insurance coverage under a group health insurance policy 72 hours after termination of employment, for any reason other than layoff or if an employee voluntarily terminates employment.

If the employer chooses to terminate the policy and wants to receive a premium credit, it is the employer's responsibility to e-mail or fax an Employer Request for Premium Credit form to us no later than 72 hours after the termination. The e-mail address and fax number are included on the form. The form will not be accepted by mail.

It is also the employer's responsibility to notify the former employee of this election within 72 hours of termination and to remit to the former employee, his or her share of any credited or returned premium.

The Employer Request for Premium Credit form is enclosed and available through the Employers site at *www.oxfordhealth.com*. Once you log in, choose the *Tools* & *Resources* tab. Under *Practical Resources*, select *Your Benefit Coverage*, and then *Forms*. The Employer Request for Premium form will be listed with Connecticut small and large group information.

If you have any questions regarding this Public Act, please contact your Oxford representative.



SOXFORD Employer Request for Premium Credit

Please complete and **e-mail or fax** this form to us **within 72 hours** of the employee's termination date. **This form will not be accepted by mail.**

E-mail: groupservices@oxfordhealth.com

Fax: 1-888-454-0386 (for large groups of 51+)

If this form is received after the 72 hours, the group will not be eligible for a premium credit.

Effective October 1, 2009, Connecticut Public Act No. 09-126 provides employers (with fully insured health plans) an election to terminate an employee's medical insurance coverage under a group health insurance policy 72 hours (3 calendar days) after termination of employment. The law applies to an employee who:

- Voluntarily terminates employment or
- Is terminated for any reason other than layoff, or relocation or closing of a covered establishment

If the employer elects to request a credit of the employee's (and dependents) pre-paid premium, this form must be completed and e-mailed or faxed within 72 hours of the employee's termination date. If this form is received after the 72-hour period, the credit request will not be processed.

Please print the following information:
Group Name:
Group ID Number:
Member Name:
Member ID:
Employee Termination Date:
Employee Termination Reason:
Benefits Administrator Name:
Signature of Benefits Administrator:
Date Signed:

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