New York Small Group Oxford USA℠ Addendum

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

I. GENERAL INFORMATION

Policy Number (OHI Use Only): ______________________________

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

1. Policyholder (full legal name of company):

2. Tax Identification Number:

II. ADMINISTRATIVE INFORMATION

Please note: All Oxford USA℠ Members are in one class.

1. Waiting period before employees become insured (may not exceed six months):

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

	IN AREA	OUT OF AREA
2. Number of Employees Eligible on Effective Date:	__________	__________
Number of Employees Enrolling:	__________	__________

Please note: The number of employees enrolling in Oxford USA℠ cannot exceed 75% of total group enrollment.

3. Continuation of Coverage:

Are there any former out-of-area employees who have been paying you for coverage since they stopped working for you? (Either COBRA or State Continuation Provisions) ❑ Yes ❑ No

If yes, please identify those individuals:

Name	Qualifying Event and Date

III. OXFORD USA PRODUCT/PLAN DESIGN

A) ❑ Oxford USA (Non-gated POS plan design options – In-network and Out-of-network)

1. Plan Designs (No referrals are required for these plan designs)

Instructions: Please select a plan option and any additional benefit options as provided below.

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6	❑ Plan 7	❑ Plan 8	❑ Plan 9	❑Plan 10
Copayment	$10	$15	$15	$15	$20	$20	$20	$25	$15/$25	$25/$40
Hospital Copayment	$0	$0	$0	$0	$0	$0	$0	$500 inpatient	$100 inpatient $100 outpatient	$500 inpatient $150 outpatient
Single Deductible	$250	$250	$500	$1,000	$500	$1,000	$2,000	$2,000	$1,000	$2,000
Family Deductible	$625	$625	$1,250	$2,500	$1,250	$2,500	$5,000	$5,000	$2,500	$5,000
Coinsurance	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Single Max. Out-of-Pocket	$1,750	$1,750	$2,000	$4,000	$3,500	$4,000	$5,000	$5,000	$4,000	$5,000
Out-of-Network	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]

2. Pharmacy Benefit:

Options	Tier 1	Tier 2	Tier 3	Mail Order	Deductible** (Please select one)
❑ Option 1	$7 Copayment	$20 Copayment	$40 Copayment	2.5x Copayment	❑ $0 ❑ $50 ❑ $100 ❑ $250 ❑ $500
❑ Option 2	$10 Copayment	$30 Copayment	$60 Copayment	2.5x Copayment	❑ $100 ❑ $250 ❑ $500
❑ Option 3	$15 Copayment	50%	50%	2.5x Copayment or 50%	❑ $0 ❑ $50 ❑ $100 ❑ $250 ❑ $500
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

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

Contraceptives:

❑ Yes (Standard) ❑ No (Qualified State Exempt Groups Only)

3. Additional Benefit Information:

❑ Vision
❑ Domestic Partner
❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Unlimited Mental Health***

- In-network coverage is through UnitedHealthcare Choice Plus Network
- $50 Emergency Room Copayment
- 90 Physical Therapy visits per condition, per lifetime

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Dependent Student Eligibility Cutoff:

❑ Mandated Offering - Dependent Age Extension to 29
❑ Other: ______________________________
SUBJECT TO HOME OFFICE APPROVAL

[1] When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provder's billed charge.

III. OXFORD USA PRODUCT/PLAN DESIGN(CONTINUED)

B) ❑ Oxford USA, (Freedom Plan Metro Access Non-gated – No referrals required)

1. Plan Designs (No referrals are required for these plan designs)

Instructions: Please select a plan option and any additional benefit options as provided below.

Options	❑ Option 1	❑ Option 2	❑ Option 3
Office visit copayment	$20 PCP/$30 specialist	$30 PCP/$50 specialist	$50 PCP/$75 specialist
Hospital copayment	$500 per admission	$500 per admission	$750 per admission
Outpatient/Hospital ambulatory surgery	$250 copayment	$500 copayment	$500 copayment
Out-of-network deductible - Single/Family	$2,000/$6,000	$3,000/$9,000	$3,000/$9,000
Out-of-network coinsurance - Single/Family	70% to $10,000/$30,000	70% to $10,000/$30,000	70% to $20,000/$60,000
Out-of-network Reimbursement	140% of Medicare rate[1]	140% of Medicare rate[1]	140% of Medicare rate[1]

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

2. Pharmacy Benefit

Options	Tier 1	Tier 2	Tier 3	Mail Order	Deductible** (Please select one)
❑ Option 1	$10 copayment	$30 copayment	$60 copayment	2.5x copayment	❑$100 ❑$250 ❑$500
❑ Option 2	$15 copayment	50%	50%	2.5x copayment or 50%	❑$50 ❑$100 ❑$250 ❑$500
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

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

3. Additional Benefit Options: ❑ Vision ❑ Domestic Partner ❑ Other: ______________________
SUBJECT TO HOME OFFICE APPROVAL

❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
❑ Mandated Offering - Dependent Age Extension to 29
❑ Unlimited Mental Health***

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Contraceptives: ❐ Yes (Standard) ❐ No (Qualified State Exempt Groups Only)

C) ❑ Oxford USA (Freedom Plan Direct plan design options – NON-GATED)

1. Plan Designs (No referrals are required for these plan designs) In-network/Out-of-network

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4
Copayment	$25/$40	$25/$40	$30/$50	$50/$75
Single Deductible	$500/$1,000	$1,000/$2,000	$2,000/$2,000	$2,500/$6,000
Family Deductible	$1,250/$2,500	$2,500/$5,000	$5,000/$5,000	$6,250/$15,000
Coinsurance	80%/60%	80%/60%	80%/60%	80%/60%
Out-of-network Reimbursement	140% of Medicare rate[1]	140% of Medicare rate[1]	140% of Medicare rate[1]	140% of Medicare rate[1]
Single Max Out-of-Pocket	$2,500/$5,000	$3,000/$6,000	$4,000/$6,000	$6,500/$18,000

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

2. Pharmacy Benefit:

Options	Tier 1	Tier 2	Tier 3	Mail Order	Deductible** (Please select one)
❑ Option 1	$10 Copayment	$30 Copayment	$60 Copayment	2.5x Copayment	❑ $100 ❑ $250 ❑ $500
❑ Option 2	$15 Copayment	50%	50%	2.5x Copayment or 50%	❑ $50 ❑ $100 ❑ $150 ❑ $250
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

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

Contraceptives:

❒ Yes (Standard) ❒ No (Qualified State Exempt Groups Only)

3. Additional Benefit Information: ❑ Vision ❑ Domestic Partner ❑ Other: ____________________

SUBJECT TO HOME OFFICE APPROVAL

❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

❑ Unlimited Mental Health***

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Dependent Student Eligibility Cutoff: ❑ Mandated Offering - Dependent Age Extension to 29

D) Oxford USA HSA Direct

Please note: Groups enrolling in the Oxford USA HSA Direct must also fill out an Oxford HSA Bank Notification Form (#7423).
No referrals are required for these plan designs.

In-Network/Out-of-Network

Options	❑ 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 Maximum Out-of-Pocket	$3,250/ $6,000	$3,000/ $5,000	$3,850/ $5,850	$1,250/ $5,000	$2,000/ $5,000	$2,850/ $5,850
Family Medical Maximum Out-of-Pocket	$6,500/ $12,000	$6,000/ $10,000	$7,700/ $11,700	$2,500/ $10,000	$4,000/ $10,000	$5,700/ $11,700
Out-of-Network Reimbursement	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]	140% of Medicare Rate[1]

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

Additional Benefit Options: ❑ Vision ❑ Domestic Partner ❑ Other: ____________________

SUBJECT TO HOME OFFICE APPROVAL

❑ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances

❑ Mandated Offering - Dependent Age Extension to 29

❑ Unlimited Mental Health***

***Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

III. OXFORD USA PRODUCT/PLAN DESIGN(CONTINUED)

Please select optional prescription drug coverage** (Required):

Options	Tier 1	Tier 2	Tier 3	Mail-Order
❑ Option 1	$10 copayment	$30 copayment	$60 copayment	2.5x copayment
❑ Option 2	$15 copayment	50%	50%	2.5x copayment or 50%

Contraceptives:

❐ Yes (Standard)

❐ No (Qualified State Exempt Groups Only)

**NOTE: As of April 1, 2005, all in-network medical and pharmacy services are subject to the in-nework deductible. Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copayment will apply based on the option selected at plan inception. Out-of-network benefits are accumulated separately. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket have been met.

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. APPLICANT AGREEMENT

This Addendum forms a part of the Application between the Group and Us. In the event of a conflict between the provisions of this Addendum and the Application, the provisions of this Addendum will prevail. All other terms and conditions of the Application remain in full force and effect. Nothing contained in this Addendum will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Application to which this Addendum is attached, other than as specifically stated herein. 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, or conceals for the purpose of misleading, 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 five thousand dollars and the stated value of the claim for each such violation.

Dated at: ______________________ this ______________________ day of ______________________________ 20 __________

Oxford Health Insurance, Inc.

X

Signature of Authorized Officer of the Company Title

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

Witness Duly Licensed Resident Agent/Broker