

# New York Small Group Application – OHI

Oxford Health Insurance, Inc.  
**Mailing Address:** Group Enrollment Department, 14 Central Park Drive, Hooksett, NH 03106

## I. GENERAL INFORMATION

**1. Full legal name of group:**

**2. Primary address of group:**   
(Street Address  
 City, State, ZIP Code)  
 No P.O. Box

**3. Plan Administrator/Contact:**

a. Name

b. Title

c. Address (If different from primary)

City, State, ZIP Code

d. Phone Number    Ext.

e. Fax Number

f. Email Address:

g. Add'l Contact & Number

**4. Name and title of person to receive billing statements:**

a. Name

b. Title

c. Address (If different from primary)

City, State, ZIP Code

d. Phone Number    Ext.

e. Fax Number

**5. Full legal name of each subsidiary and/or affiliated company whose employees are to be covered (if applicable):**

<input type="text"/>
<input type="text"/>
<input type="text"/>

**6. Nature of business:**

**7. SIC Code:**

**8. Tax Identification Number:**

## II. ADMINISTRATIVE INFORMATION

The term “coverage” means the benefits provided by Oxford, pursuant to the Group Certificate of Coverage. To be eligible for small group coverage, you must be located in a county where we offer this Oxford product and have at least 1 but not more than 100 full-time equivalent employees over the prior calendar year.

1. Effective date: We request that this coverage be effective \_\_\_\_\_.
2. Anniversary date: The anniversary date is the first day of the calendar month that is closest to the effective date.
3. Open enrollment period: The open enrollment period is the month prior to your anniversary date. The open enrollment effective date is the first of the month following the period.
4. Enter the Prior Calendar Year Full-time Equivalent Total Number of Employees \_\_\_\_\_  
(This information will be used to determine whether you are a small group.)  
For purposes of determining your number of full-time equivalent employee count over the prior calendar year, please use the following calculation:
  - (1) For each month during the calendar year, count all full-time employees. (A full-time employee is one who works an average of 30 or more hours per week.)
  - (2) For each month during the calendar year, count all HOURS worked by part-time employees and divide by 120.
  - (3) Add the number resulting from (2) to the number resulting from (1) for each month during calendar year.
    - a) Only if the total number is equal to or exceeds 101 employees, then you must verify that “seasonal workers” who worked less than 120 days were not included and remove them from the calculation.
    - b) A “seasonal worker” is one who performs labor or services on a seasonal basis as defined by the Federal Secretary of Labor, including retail workers employed only during a holiday season.
  - (4) Divide the total number of (3) by 12. If the business was new and did not operate for all of the previous calendar year, divide by the number of months of data that were used.
5. Enter the Prior Calendar Year Average Total Number of Employees \_\_\_\_\_  
(This question is included for Department of Health and Human Services reporting purposes only and does not determine group size.)  
Under Health Care Reform law, the average total number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is any person whose work is controlled and directed by the employer (also known as common law employees). Employees may work full-time, part-time and on a seasonal basis. Individuals do not have to qualify for medical coverage to be considered employees. Although employees generally will receive a W-2, include in your employee count common law employees who may not always get W-2s.  
To calculate the annual average, add all the monthly employee totals together then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the “monthly value” to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).
6. How many eligible employees does this group have? \_\_\_\_\_  
Eligible employees: Active permanent employees of the employer and of all subsidiaries or affiliates of a corporate employer who work **20 or more** hours per week and are eligible for health benefits through the employer’s group health plan. Eligible employees do not include:
  - any person who does not meet the common law employee definition under Department of Labor and Internal Revenue Code rules or
  - any former employee who is covered through retiree benefits, COBRA or state continuation.An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours and occupational duties. Employees who work less than 20 hours per week are not eligible employees and may not enroll in any Oxford products. If coverage is limited to specific class(es) of employees, the classes must be specified in response to question 20 below.  
If the employer does not offer group health coverage to all eligible employees, eligible employees should include (1) the number of eligible employees who work in the state of New York and (2) if the employer offers Oxford coverage to out-of-state employees, the number of out-of-state eligible employees.
7. Total number of employees being offered coverage through this product: \_\_\_\_\_  
Of the eligible employees who work 20 or more hours per week, please list all employees who will be offered coverage under this policy. If coverage is limited to specific class(es) of employees, the classes must be specified in response to question 20 below.  
Groups seeking to purchase insurance, also must meet the minimum participation requirements for coverage, except during the annual open enrollment period from November 15th - December 15th. Please see our underwriting guidelines for details on our minimum participation requirements.
8. If the employer offers retiree coverage, how many eligible retired former employees does this group have? \_\_\_\_\_  
Integration with Medicare benefits: Health benefits covered by Medicare Part A and B are carved out for retired employees aged 65 or over and their dependents aged 65 or over, if the group offers retiree coverage.
9. Total number of employees and former employees enrolling: \_\_\_\_\_  
Enrolling means the total number of eligible employees, COBRA or state continuation enrollees, and retired employees (if applicable) accepting coverage with any Oxford product.
  - a. of those former employees enrolling, how many are retired? \_\_\_\_\_
  - b. of those former employees enrolling, how many are enrolling through COBRA or state continuation? \_\_\_\_\_

## II. ADMINISTRATIVE INFORMATION (CONTINUED)

10. Total number of employees waiving coverage for the following reasons:
- a. A spouse's health benefit plan: \_\_\_\_\_
  - b. Medicare: \_\_\_\_\_
  - c. Medicaid: \_\_\_\_\_
  - d. Veteran's coverage: \_\_\_\_\_
  - e. Parental waiver: \_\_\_\_\_
  - f. All other waivers (include number of eligible employees enrolling in other employer-sponsored HMO or insurance coverage): \_\_\_\_\_

11. Total number of valid waivers (a – e): \_\_\_\_\_

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

Please list other current or past group health or HMO coverage offered by Employer in the last three years:

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

13. Is your group subject to COBRA (20 or more total employees during at least 50% of the working days in the previous calendar year)?  
 Yes     No

14. Subject to ERISA?     Yes     No (Most private sector plans are ERISA plans.)

If No, please indicate appropriate category:

- Church (Additional information needed)
- Indian Tribe – Commercial Business
- Foreign Government/Foreign Embassy
- Federal Government
- Non-Federal Government (State, Local or Tribal Gov.)
- Non-ERISA Other \_\_\_\_\_

15. Does your group sponsor a plan that covers employees of more than one employer?     Yes     No

If you answered Yes, then indicate which of the following most closely describes your plan:

- Professional Employer Organization (PEO)
- Multiple Employer Welfare Arrangement (MEWA)
- Taft Hartley Union
- Governmental
- Church
- Employer Association

16. Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)?     Yes     No

17. Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?     Yes     No

18. Do you have common ownership with any other businesses?     Yes     No

If you own multiple companies, or a parent-subsidary relationship exists between your company and another, this may indicate common ownership of businesses.

19. UnitedHealthcare's Leave of Absence (LOA) Policy; Eligibility for Medical Coverage

If the employee is on an employer approved leave of absence and the employer continues to pay required medical premiums, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e. temporarily laid-off). (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by local, state or federal rules.

If the employee's medical coverage terminates under this LOA policy, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?

- Yes, we continue medical coverage during an approved leave of absence for full time\* employees (as defined on page 2).
- No, we do not offer medical coverage during a leave of absence.

**The Employer's decision to refuse to offer coverage cannot be based upon health status related factors.**

## II. ADMINISTRATIVE INFORMATION (CONTINUED)

### 20. Eligible employee class(es), Waiting period and Termination:

If coverage is being limited to particular class(es) of employees, please specify class definition(s) below. An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours, and occupational duties. Although an Employer may establish a class of employees who work less than 20 hours per week, Oxford products are not available to employees who work less than 20 hours per week.

We do not have waiting periods for new employees. Employers may set a waiting period for new employees from 0 to 90 days. A newly eligible employee has 30 days to enroll from the first day of eligibility.

If classes and waiting periods are not specified below, all eligible employees who work 20 or more hours per week will be eligible for group health benefits under an Oxford policy without a waiting period.

Eligibility and Termination: The employee will become eligible on the latter of the effective date of this plan or the date selected below (check appropriate date).

### CLASS I

Definition of Class I \_\_\_\_\_

#### i) Eligibility/Termination

- Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

#### ii) Eligibility/Termination

- On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

#### iii) Waiting Period for Rehires

Maximum Waiting Period is 90 days

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

### CLASS II

Definition of Class II \_\_\_\_\_

#### i) Eligibility/Termination

- Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

#### ii) Eligibility/Termination

- On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

#### iii) Waiting Period for Rehires

Maximum Waiting Period is 90 days

Waiting Period Waived for Rehires?  Yes  No

If yes, waived if rehired within \_\_\_\_\_ months.

### III. PRODUCT AND PLAN DESIGNS

#### A. Platinum Plans

Option	□ NY P FRDM NG 20/40/100 EPO 20	□ NY P FRDM NG 5/15/100 EPO 20	□ NY P FRDM NG 20/40/100 PPO 20	□ NY P FRDM NG 5/15/100 PPO 20
<b>Network</b>	Freedom	Freedom	Freedom	Freedom
<b>Gated/Non-Gated</b>	Non-Gated	Non-Gated	Non-Gated	Non-Gated
<b>Copayment:</b> <b>PCP</b>	\$20	\$5	\$20	\$5
<b>Specialist</b>	\$40	\$15	\$40	\$15
<b>In-Network Deductible (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>In-Network Out of Pocket (Single/Family)</b>	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000
<b>In-network Coinsurance</b>	N/A	N/A	N/A	N/A
<b>Outpatient Facility</b>	Freestanding: \$100 Hospital: \$300	Freestanding: \$50 Hospital: \$100	Freestanding: \$100 Hospital: \$300	Freestanding: \$50 Hospital: \$100
<b>Inpatient Facility</b>	\$400 per admit	\$200 per admit	\$400 per admit	\$200 per admit
<b>Emergency Room</b>	\$200	\$200	\$200	\$200
<b>Out of Network Deductible (Single/Family)</b>	N/A	N/A	\$3,000/\$6,000	\$2,000/\$4,000
<b>Out of Network Out of Pocket (Single/Family)</b>	N/A	N/A	\$7,500/\$15,000	\$5,000/\$10,000
<b>Out of Network Coinsurance</b>	N/A	N/A	30%	30%
<b>Prescription Drug</b>	Tier 1 - \$5 Tier 2 - \$30* Tier 3 - \$60* Mail order = 2.5x copayment *after \$50 Rx deductible	Tier 1 - \$5 Tier 2 - \$30* Tier 3 - \$60* Mail order = 2.5x copayment *after \$50 Rx deductible	Tier 1 - \$5 Tier 2 - \$30* Tier 3 - \$60* Mail order = 2.5x copayment *after \$50 Rx deductible	Tier 1 - \$5 Tier 2 - \$30* Tier 3 - \$60* Mail order = 2.5x copayment *after \$50 Rx deductible

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### A. Platinum Plans (continued)

Option	<input type="checkbox"/> NY P FRDM NG 20/40/100 PPO FAIR 20	<input type="checkbox"/> NY P LBTY GT 15/35/250/90 EPO LA 20	<input type="checkbox"/> NY P LBTY NG 40/80/80 EPO 411 20
<b>Network</b>	Freedom	Liberty	Liberty
<b>Gated/Non-Gated</b>	Non-Gated	Gated	Non-Gated
<b>Copayment: PCP</b>	\$20	\$15	\$5 (first 4 visits) \$40 (subsequent visits)
<b>Specialist</b>	\$40	\$35	\$25 (first visit) \$80 (subsequent visits)
<b>In-Network Deductible (Single/Family)</b>	N/A	\$250/\$500	N/A
<b>In-Network Out of Pocket (Single/Family)</b>	\$2,500/\$5,000	\$3,000/\$6,000	\$2,000/\$4,000
<b>In-network Coinsurance</b>	N/A	10%	20%
<b>Outpatient Facility</b>	Freestanding: \$100 Hospital: \$300	Freestanding and Hospital: 10% after deductible	Freestanding: \$250 Hospital: \$500
<b>Inpatient Facility</b>	\$400 per admit	10% after deductible	\$1,000 per admit
<b>Emergency Room</b>	\$200	10% after deductible	50%
<b>Out of Network Deductible (Single/Family)</b>	\$3,000/\$6,000	N/A	N/A
<b>Out of Network Out of Pocket (Single/Family)</b>	\$7,500/\$15,000	N/A	N/A
<b>Out of Network Coinsurance</b>	20%	N/A	N/A
<b>Prescription Drug</b>	Tier 1 - \$5 Tier 2 - \$30* Tier 3 - \$60* Mail order = 2.5x copayment *after \$50 Rx deductible	Tier 1 - \$5 Tier 2 - \$30* Tier 3 - \$60* Mail order = 2.5x copayment *after \$150 Rx deductible	Tier 1 - \$5 Tier 2 - \$30* Tier 3 - \$60* Mail order = 2.5x copayment *after \$150 Rx deductible

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

**Additional Benefit Options:**

Domestic Partner

Mandated Offering – Dependent Age Extension to 29

**Contraceptives**  Yes (Standard)  No (Qualified State-Exempt Groups Only)

**Medicare Part D 28% Subsidy** – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare-eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### B. Gold Plans

Option	<input type="checkbox"/> NY G FRDM NG 15/35/1000/90 EPO 20	<input type="checkbox"/> NY G FRDM NG 25/40/1250/80 EPO 20	<input type="checkbox"/> NY G FRDM NG 30/60/2250/70 EPO 20	<input type="checkbox"/> NY G FRDM NG 50/50/750/90 EPO 20
<b>Network</b>	Freedom	Freedom	Freedom	Freedom
<b>Gated/Non-Gated</b>	Non-Gated	Non-Gated	Non-Gated	Non-Gated
<b>Copayment:</b>				
<b>PCP</b>	\$15	\$25	\$30	\$50
<b>Specialist</b>	\$35	\$40	\$60	\$50
<b>In-Network Deductible (Single/Family)</b>	\$1,000/\$2,000	\$1,250/\$2,500	\$2,250/\$4,500	\$750/\$1,500
<b>In-Network Out of Pocket (Single/Family)</b>	\$6,500/\$13,000	\$5,000/\$10,000	\$8,150/\$16,300	\$5,200/\$10,400
<b>In-network Coinsurance</b>	10%	20%	30%	10%
<b>Outpatient Facility</b>	Freestanding: \$150 after deductible Hospital: \$300 after deductible	Freestanding: \$150 after deductible Hospital: \$250 after deductible	Freestanding and Hospital: 30% after deductible	Freestanding: \$150 after deductible Hospital: \$250 after deductible
<b>Inpatient Facility</b>	10% after deductible	20% after deductible	30% after deductible	\$250 per day up to \$2,500 annual maximum after deductible
<b>Emergency Room</b>	\$500	\$400	\$500	\$500
<b>Out of Network Deductible (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>Out of Network Out of Pocket (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>Out of Network Coinsurance</b>	N/A	N/A	N/A	N/A
<b>Prescription Drug</b>	Tier 1 - \$15 Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after \$100 Rx deductible	Tier 1 - \$15 Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after \$100 Rx deductible	Tier 1 - \$15 Tier 2 - \$45* Tier 3 - \$75* Mail order = 2.5x copayment *after \$100 Rx deductible	Tier 1 - \$10 Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after \$100 Rx deductible

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### B. Gold Plans (Continued)

Option	☐ NY G FRDM NG 1500/90 EPO HSA 20	☐ NY G FRDM NG 25/40/1000/80 PPO 20	☐ NY G FRDM NG 1500/90 PPO HSA 20	☐ NY G LBTY GT 30/60/1000/100 EPO 20
<b>Network</b>	Freedom	Freedom	Freedom	Liberty
<b>Gated/Non-Gated</b>	Non-Gated	Non-Gated	Non-Gated	Gated
<b>Copayment:</b> <b>PCP</b> <b>Specialist</b>	10% after deductible 10% after deductible	\$25 \$40	10% after deductible 10% after deductible	\$30 \$60
<b>In-Network Deductible (Single/Family)</b>	\$1,500/\$3,000	\$1,000/\$2,000	\$1,500/\$3,000	\$1,000/\$2,000
<b>In-Network Out of Pocket (Single/Family)</b>	\$4,000/\$8,000	\$5,800/\$11,600	\$4,000/\$8,000	\$5,400/\$10,800
<b>In-network Coinsurance</b>	10%	20%	10%	N/A
<b>Outpatient Facility</b>	Freestanding and Hospital: 10% after deductible	Freestanding: \$150 after deductible Hospital: \$250 after deductible	Freestanding and Hospital: 10% after deductible	Freestanding: \$150 after deductible Hospital: \$250 after deductible
<b>Inpatient Facility</b>	10% after deductible	20% after deductible	10% after deductible	\$500 per day up to \$2,000 per admit after deductible
<b>Emergency Room</b>	10% after deductible	\$500	10% after deductible	\$500
<b>Out of Network Deductible (Single/Family)</b>	N/A	\$3,000 \$6,000	\$3,000 \$6,000	N/A
<b>Out of Network Out of Pocket (Single/Family)</b>	N/A	\$7,500 \$15,000	\$7,500 \$15,000	N/A
<b>Out of Network Coinsurance</b>	N/A	40%	40%	N/A
<b>Prescription Drug</b>	Tier 1 - \$10* Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after medical deductible	Tier 1 - \$10 Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after \$100 Rx deductible	Tier 1 - \$10* Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after medical deductible	Tier 1 - \$15 Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after \$100 Rx deductible



### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### B. Gold Plans (Continued)

Option	<input type="checkbox"/> NY G LBTY NG 30/60/2000/70 EPO 20	<input type="checkbox"/> NY G LBTY NG 40/80/2000/80 EPO 411 20	<input type="checkbox"/> NY G LBTY NG 25/50/100 EPO ZD 20
<b>Network</b>	Liberty	Liberty	Liberty
<b>Gated/Non-Gated</b>	Non-Gated	Non-Gated	Non-Gated
<b>Copayment:</b>			
<b>PCP</b>	\$30	\$5 (first 4 visits) \$40 (subsequent visits)	\$25
<b>Specialist</b>	\$60	\$25 (first visit) \$80 (subsequent visits)	\$50
<b>In-Network Deductible (Single/Family)</b>	\$2,000/\$4,000	\$2,000/\$4,000	N/A
<b>In-Network Out of Pocket (Single/Family)</b>	\$7,900/\$15,800	\$4,000/\$8,000	\$5,000/\$10,000
<b>In-network Coinsurance</b>	30%	20%	N/A
<b>Outpatient Facility</b>	Freestanding and Hospital: 30% after deductible	Freestanding: \$250 after deductible Hospital: \$500 after deductible	Freestanding: \$150 Hospital: \$500
<b>Inpatient Facility</b>	30% after deductible	\$1,000 per admit after deductible	\$500 per admit
<b>Emergency Room</b>	\$500	50% after deductible	\$750
<b>Out of Network Deductible (Single/Family)</b>	N/A	N/A	N/A
<b>Out of Network Out of Pocket (Single/Family)</b>	N/A	N/A	N/A
<b>Out of Network Coinsurance</b>	N/A	N/A	N/A
<b>Prescription Drug</b>	Tier 1 - \$15 Tier 2 - \$45* Tier 3 - \$75* Mail order = 2.5x copayment *after \$100 Rx deductible	Tier 1 - \$5 Tier 2 - \$30* Tier 3 - \$60* Mail order = 2.5x copayment *after \$150 Rx deductible	Tier 1 - \$10 Tier 2 - \$65* Tier 3 - \$90* Mail order = 2.5x copayment *after \$100 Rx deductible

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

**Additional Benefit Options:**

Domestic Partner

Mandated Offering – Dependent Age Extension to 29

**Contraceptives**  Yes (Standard)  No (Qualified State-Exempt Groups Only)

**Medicare Part D 28% Subsidy** – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare-eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### C. Silver Plans

Option	<input type="checkbox"/> NY S FRDM NG 40/70/2500/65 EPO 20	<input type="checkbox"/> NY S FRDM NG 2000/70 EPO HSA 20	<input type="checkbox"/> NY S FRDM NG 25/50/2000/80 EPO HSA 20
<b>Network</b>	Freedom	Freedom	Freedom
<b>Gated/Non-Gated</b>	Non-Gated	Non-Gated	Non-Gated
<b>Copayment: PCP Specialist</b>	\$40 \$70	30% after deductible 30% after deductible	\$25 after deductible \$50 after deductible
<b>In-Network Deductible (Single/Family)</b>	\$2,500/\$5,000	\$2,000/\$4,000	\$2,000/\$4,000
<b>In-Network Out of Pocket (Single/Family)</b>	\$8,150/\$16,300	\$6,750/\$13,500	\$6,400/\$12,800
<b>In-network Coinsurance</b>	35%	30%	20%
<b>Outpatient Facility</b>	Freestanding and Hospital: 35% after deductible	Freestanding and Hospital: 30% after deductible	Freestanding: \$150 after deductible Hospital: \$250 after deductible
<b>Inpatient Facility</b>	35% after deductible	30% after deductible	20% after deductible
<b>Emergency Room</b>	50% after deductible	30% after deductible	\$500 after deductible
<b>Out of Network Deductible (Single/Family)</b>	N/A	N/A	N/A
<b>Out of Network Out of Pocket (Single/Family)</b>	N/A	N/A	N/A
<b>Out of Network Coinsurance</b>	N/A	N/A	N/A
<b>Prescription Drug</b>	Tier 1 - \$15 Tier 2 - \$45* Tier 3 - \$75* Mail order = 2.5x copayment *after \$200 Rx deductible	Tier 1 - \$15* Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after medical deductible	Tier 1 - \$15* Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after medical deductible

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### C. Silver Plans (Continued)

Option	<input type="checkbox"/> NY S FRDM NG 40/70/2500/65 PPO 20	<input type="checkbox"/> NY S FRDM NG 30/60/2000/80 PPO HSA 20	<input type="checkbox"/> NY S LBTY GT 25/50/3500/50 EPO 20
<b>Network</b>	Freedom	Freedom	Liberty
<b>Gated/Non-Gated</b>	Non-Gated	Non-Gated	Gated
<b>Copayment: PCP Specialist</b>	\$40 \$70	\$30 after deductible \$60 after deductible	\$25 \$50
<b>In-Network Deductible (Single/Family)</b>	\$2,500/\$5,000	\$2,000/\$4,000	\$3,500/\$7,000
<b>In-Network Out of Pocket (Single/Family)</b>	\$8,150/\$16,300	\$6,400/\$12,800	\$8,150/\$16,300
<b>In-network Coinsurance</b>	35%	20%	50%
<b>Outpatient Facility</b>	Freestanding and Hospital: 35% after deductible	Freestanding: \$150 after deductible Hospital: \$250 after deductible	Freestanding and Hospital: 50% after deductible
<b>Inpatient Facility</b>	35% after deductible	20% after deductible	50% after deductible
<b>Emergency Room</b>	50% after deductible	20% after deductible	50% after deductible
<b>Out of Network Deductible (Single/Family)</b>	\$4,000/\$8,000	\$4,000/\$8,000	N/A
<b>Out of Network Out of Pocket (Single/Family)</b>	\$10,000/\$20,000	\$10,000/\$20,000	N/A
<b>Out of Network Coinsurance</b>	50%	50%	N/A
<b>Prescription Drug</b>	Tier 1 - \$15 Tier 2 - \$45* Tier 3 - \$75* Mail order = 2.5x copayment *after \$200 Rx deductible	Tier 1 - \$15* Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after medical deductible	Tier 1 - \$15 Tier 2 - \$65* Tier 3 - \$85* Mail order = 2.5x copayment *after \$100 Rx deductible

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### C. Silver Plans (Continued)

Option	<input type="checkbox"/> NY S LBTY NG 30/75/3000/60 EPO 20	<input type="checkbox"/> NY S LBTY NG 40/70/2500/65 EPO 20	<input type="checkbox"/> NY S LBTY NG 25/50/2000/80 EPO HSA 20
<b>Network</b>	Liberty	Liberty	Liberty
<b>Gated/Non-Gated</b>	Non-Gated	Non-Gated	Non-Gated
<b>Copayment:</b> <b>PCP</b> <b>Specialist</b>	\$30 \$75	\$40 \$70	\$25 after deductible \$50 after deductible
<b>In-Network Deductible (Single/Family)</b>	\$3,000/\$6,000	\$2,500/\$5,000	\$2,000/\$4,000
<b>In-Network Out of Pocket (Single/Family)</b>	\$8,150/\$16,300	\$8,150/\$16,300	\$6,400/\$12,800
<b>In-network Coinsurance</b>	40%	35%	20%
<b>Outpatient Facility</b>	Freestanding and Hospital: 40% after deductible	Freestanding and Hospital: 35% after deductible	Freestanding: \$150 after deductible Hospital: \$250 after deductible
<b>Inpatient Facility</b>	40% after deductible	35% after deductible	20% after deductible
<b>Emergency Room</b>	\$600 after deductible	50% after deductible	\$500 after deductible
<b>Out of Network Deductible (Single/Family)</b>	N/A	N/A	N/A
<b>Out of Network Deductible (Single/Family)</b>	N/A	N/A	N/A
<b>Out of Network Coinsurance</b>	N/A	N/A	N/A
<b>Prescription Drug</b>	Tier 1 - \$15 Tier 2 - \$65* Tier 3 - 50% up to \$800 maximum* Mail order = 2.5x copayment *after \$100 Rx deductible	Tier 1 - \$15 Tier 2 - \$45* Tier 3 - \$75* Mail order = 2.5x copayment *after \$200 Rx deductible	Tier 1 - \$15* Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after medical deductible

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

**Additional Benefit Options:**

Domestic Partner

Mandated Offering – Dependent Age Extension to 29

**Contraceptives**  Yes (Standard)  No (Qualified State-Exempt Groups Only)

**Medicare Part D 28% Subsidy** – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare-eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### D. Bronze Plans

Option	<input type="checkbox"/> NY B FRDM NG 5500/70 EPO HSA 20	<input type="checkbox"/> NY B LBTY NG 5500/70 EPO HSA 20	<input type="checkbox"/> NY B LBTY NG 6750/100 EPO HSA 20
<b>Network</b>	Freedom	Liberty	Liberty
<b>Gated/Non-Gated</b>	Non-Gated	Non-Gated	Non-Gated
<b>Copayment: PCP Specialist</b>	30% after deductible 30% after deductible	30% after deductible 30% after deductible	No Charge after deductible No Charge after deductible
<b>In-Network Deductible (Single/Family)</b>	\$5,500/\$11,000	\$5,500/\$11,000	\$6,750/\$13,500
<b>In-Network Out of Pocket (Single/Family)</b>	\$6,700/\$13,400	\$6,700/\$13,400	\$6,750/\$13,500
<b>In-network Coinsurance</b>	30%	30%	N/A
<b>Outpatient Facility</b>	Freestanding and Hospital: 30% after deductible	Freestanding and Hospital: 30% after deductible	Freestanding and Hospital: No Charge after deductible
<b>Inpatient Facility</b>	30% after deductible	30% after deductible	No Charge after deductible
<b>Emergency Room</b>	50% after deductible	50% after deductible	No Charge after deductible
<b>Out of Network Deductible (Single/Family)</b>	N/A	N/A	N/A
<b>Out of Network Out of Pocket (Single/Family)</b>	N/A	N/A	N/A
<b>Out of Network Coinsurance</b>	N/A	N/A	N/A
<b>Prescription Drug</b>	Tier 1 - \$10* Tier 2 - \$40* Tier 3 - \$80* Mail order = 2.5x copayment *after medical deductible	Tier 1 - \$10* Tier 2 - \$40* Tier 3 - \$80* Mail order = 2.5x copayment *after medical deductible	Tier 1 - No charge* Tier 2 - No charge* Tier 3 - No charge* *after medical deductible

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### D. Bronze Plans (Continued)

Option	<input type="checkbox"/> NY B LBTY NG 25/75/4000/70 EPO HSA 20	<input type="checkbox"/> NY B LBTY NG 30/60/6000/80 PPO HSA 20
Network	Liberty	Liberty
Gated/Non-Gated	Non-Gated	Non-Gated
Copayment: PCP Specialist	\$25 after deductible \$75 after deductible	\$30 after deductible \$60 after deductible
In-Network Deductible (Single/Family)	\$4,000/\$8,000	\$6,000/\$12,000
In-Network Out of Pocket (Single/Family)	\$6,750/\$13,500	\$6,550/\$13,100
In-network Coinsurance	30%	20%
Outpatient Facility	Freestanding and Hospital: 30% after deductible	Freestanding and Hospital: 20% after deductible
Inpatient Facility	30% after deductible	20% after deductible
Emergency Room	30% after deductible	20% after deductible
Out of Network Deductible (Single/Family)	N/A	\$10,000/\$20,000
Out of Network Out of Pocket (Single/Family)	N/A	\$25,000/\$50,000
Out of Network Coinsurance	N/A	20%
Prescription Drug	Tier 1 - 30%* Tier 2 - 30%* Tier 3 - 30%* *after medical deductible	Tier 1 - \$15* Tier 2 - \$35* Tier 3 - \$75* Mail order = 2.5x copayment *after medical deductible

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

**Additional Benefit Options:**

Domestic Partner

Mandated Offering – Dependent Age Extension to 29

**Contraceptives**  Yes (Standard)  No (Qualified State-Exempt Groups Only)

**Medicare Part D 28% Subsidy** – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare-eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### E. Metro Plans

Option	<input type="checkbox"/> NY P MTRO GT 15/30/100 EPO 20	<input type="checkbox"/> NY G MTRO GT 25/40/1250/80 EPO 20	<input type="checkbox"/> NY G MTRO NG 25/40/1250/80 EPO ME 20
<b>Network</b>	Metro	Metro	Metro
<b>Gated/Non-Gated</b>	Gated	Gated	Non-Gated
<b>Copayment:</b> <b>PCP</b> <b>Specialist</b>	\$15 \$30	\$25 \$40	\$25 \$40
<b>In-Network Deductible (Single/Family)</b>	N/A	\$1,250/\$2,500	\$1,250/\$2,500
<b>In-Network Out of Pocket (Single/Family)</b>	\$2,500/\$5,000	\$5,500/\$11,000	\$5,000/\$10,000
<b>In-network Coinsurance</b>	N/A	20%	20%
<b>Outpatient Facility:</b>	Freestanding: \$100 Hospital: \$500	Freestanding: \$200 after deductible	Freestanding: \$200 after deductible
<b>Inpatient Facility</b>	\$200 per day up to \$800 per admit	20% after deductible	20% after deductible
<b>Emergency Room</b>	\$200	\$500	\$400
<b>Out of Network Deductible (Single/Family)</b>	N/A	N/A	N/A
<b>Out of Network Out of Pocket (Single/Family)</b>	N/A	N/A	N/A
<b>Out of Network Coinsurance</b>	N/A	N/A	N/A
<b>Prescription Drug</b>	Tier 1 - \$10 Tier 2 - \$65* Tier 3 - \$90* Mail order = 2.5x copayment *after \$100 Rx deductible	Tier 1 - \$10 Tier 2 - \$65* Tier 3 - \$90* Mail order = 2.5x copayment *after \$100 Rx deductible	Tier 1 - \$10 Tier 2 - \$65* Tier 3 - \$90* Mail order = 2.5x copayment *after \$100 Rx deductible

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### E. Metro Plans (Continued)

Option	<input type="checkbox"/> NY S MTRO GT 30/80/3000/70 EPO 20	<input type="checkbox"/> NY S MTRO GT 35/50/3500/70 EPO HSA 20	<input type="checkbox"/> NY S MTRO NG 30/80/3000/70 EPO ME 20	<input type="checkbox"/> NY S MTRO NG 50/100/100 EPO ZD 20
<b>Network</b>	Metro	Metro	Metro	Metro
<b>Gated/Non-Gated</b>	Gated	Gated	Non-Gated	Non-Gated
<b>Copayment: PCP Specialist</b>	\$30 \$80	\$35 after deductible \$50 after deductible	\$30 \$80	\$50 \$100
<b>In-Network Deductible (Single/Family)</b>	\$3,000/\$6,000	\$3,500/\$7,000	\$3,000/\$6,000	N/A
<b>In-Network Out of Pocket (Single/Family)</b>	\$8,150/\$16,300	\$6,750/\$13,500	\$8,150/\$16,300	\$8,150/\$16,300
<b>In-network Coinsurance</b>	30%	30%	30%	N/A
<b>Outpatient Facility</b>	Freestanding and Hospital: 30% after deductible	Freestanding: \$300 after deductible Hospital: \$750 after deductible	Freestanding and Hospital: 30% after deductible	Freestanding: \$400 Hospital: \$700
<b>Inpatient Facility</b>	30% after deductible	30% after deductible	30% after deductible	\$1,000 per admit
<b>Emergency Room</b>	50% after deductible	\$500 after deductible	50% after deductible	\$1,000
<b>Out of Network Deductible (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>Out of Network Out of Pocket (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>Out of Network Coinsurance</b>	N/A	N/A	N/A	N/A
<b>Prescription Drug</b>	Tier 1 - \$10 Tier 2 - \$65* Tier 3 - \$90* Mail order = 2.5x copayment *after \$100 Rx deductible	Tier 1 - \$10* Tier 2 - \$65* Tier 3 - 50% up to \$800 maximum* Mail order = 2.5x copayment *after medical deductible	Tier 1 - \$10 Tier 2 - \$65* Tier 3 - \$90* Mail order = 2.5x copayment *after \$100 Rx deductible	Tier 1 - \$15 Tier 2 - \$65* Tier 3 - \$90* Mail order = 2.5x copayment *after \$100 Rx deductible



### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### E. Metro Plans (Continued)

Option	<input type="checkbox"/> NY B MTRO GT 40/75/5750/50 EPO HSA 20	<input type="checkbox"/> NY B MTRO GT 6750/100 EPO HSA 20
Network	Metro	Metro
Gated/Non-Gated	Gated	Gated
Copayment: PCP Specialist	\$40 after deductible \$75 after deductible	No Charge after deductible No Charge after deductible
In-Network Deductible (Single/Family)	\$5,750/\$11,500	\$6,750/\$13,500
In-Network Out of Pocket (Single/Family)	\$6,700/\$13,400	\$6,750/\$13,500
In-network Coinsurance	50%	N/A
Outpatient Facility	Freestanding: \$500 after deductible Hospital: \$1,000 after deductible	Freestanding and Hospital: No Charge after deductible
Inpatient Facility	50% after deductible	No Charge after deductible
Emergency Room	\$500 after deductible	No Charge after deductible
Out of Network Deductible (Single/Family)	N/A	N/A
Out of Network Out of Pocket (Single/Family)	N/A	N/A
Out of Network Coinsurance	N/A	N/A
Prescription Drug	Tier 1 - \$10* Tier 2 - \$65* Tier 3 - \$90* Mail order = 2.5x copayment *after medical deductible	Tier 1 - No charge* Tier 2 - No charge* Tier 3 - No charge* *after medical deductible

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

Metro plans only – Has the group been certified as eligible for the Small Business Health Options Program (SHOP)?

Yes  No

Additional Benefit Options:

Domestic Partner

Mandated Offering – Dependent Age Extension to 29

Contraceptives  Yes (Standard)  No (Qualified State-Exempt Groups Only)

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare-eligible retirees?  Yes  No

## IV. RATE INFORMATION

**Monthly Rates:** All new groups are subject to the four-tier rate structure indicated below. Rates must be included in the spaces below for application processing. Please note: All four categories must be completed.

Single	Couple	Parent/Children	Family
\$	\$	\$	\$

## V. BROKER/AGENT INFORMATION

	Broker	Co-Broker	General Agent
1. Name of Payee:			
2. Payee's Oxford Broker Code (Required):			
3. Payee's Social Security # or Federal Tax ID #:			
4. Name of Writing Agent (Required if Payee is a company):			
5. Writing Agent's Oxford Broker Code (Required if Payee is a company):			
6. Commission Split %:			
7. Sales Representative:			
Comments:			

## VI. CONSENT

### AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford to accept the Broker or General Agent named above as an authorized Benefits Administrator for purposes of processing any enrollment transactions for my company's Oxford policy (including, but not limited to, Member enrollments, Member terminations, Member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations).

This authorization shall be effective immediately and shall (check one only):

\_\_\_\_\_ Remain in place until it is expressly revoked by me in writing.

\_\_\_\_\_ Remain in place until \_\_\_\_\_.  
Date

Further, I agree that my company will be bound by the actions performed by the herein-named Broker or General Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about any Member.

## VII. COBRA & EXTENSION OF BENEFITS DATA

1. Do you have any individuals currently on COBRA continuation?  Yes  No  
If Yes, identify the number of individuals\_\_\_\_\_.
2. Are there any dependents of employees who are currently disabled or in the hospital?  Yes  No  
What is the length of the prior carrier's extension of benefits period for disabled employees or dependents? \_\_\_\_\_

## VIII. APPLICANT AGREEMENT

This Application and the premium rates proposed by Oxford are subject to approval, in writing, by Oxford and may change due to differences in actual versus proposed enrollment, selection of benefits, changes in census data or underwriting criteria, or any other changes in underwriting as determined by Oxford. We reserve the right to modify rates in the event a plan design must be modified as a result of any change, modification or clarification in law. We also retain the right to correct typographical errors or discrepancies prior to the effective date of coverage, and take other actions (for example due to a misrepresentation of a material fact) as permitted by applicable state law.

I, the undersigned, on behalf of the above named company (the "Applicant") am applying for small group health coverage and understand that the information provided will be used to determine eligibility for coverage, premium rates and for other purposes. I confirm that all information gathered herein is accurately represented, complete, and that the Applicant is not aware of any information that was not disclosed.

The Applicant confirms that we employ no more than 100 full-time equivalent employees and at least 1 full-time equivalent employee.

The Applicant understands that this Application may be chosen for an audit to confirm the information provided. Audits may be conducted before or after enrollment. If documents reviewed or submitted during an audit show that the information provided on an application was false or that the group does not meet underwriting requirements, the group will not be enrolled (audit completed prior to enrollment) or will be terminated (audit completed post enrollment).

The Applicant understands that other audits may be conducted while the Group Policy and Group Enrollment Agreement is in effect and agrees that all documents or other information that may impact coverage or premiums will be available for inspection.

The Applicant hereby acknowledges and understands that this application does not constitute any obligation by Oxford to offer coverage and no insurance will be effective unless and until the application is formally accepted, in writing, by the Oxford entity underwriting the coverage. No contract of insurance is to be implied in any way on the basis of completion and/or submission of this Application.

If coverage is formally accepted, the Applicant understands that this application and any subsequent addenda (including, but not limited to, any member application forms and renewal certifications) will become part of the Group Policy and Group Enrollment Agreement issued by Oxford. Any material misrepresentation within the application or the addenda (whether intentional or unintentional) may subject the group to termination or other action permitted by law. By signing below, the Applicant agrees to be bound by the terms and conditions of the Group Policy and Group Enrollment Agreement. The plan documents (including, but not limited to, the application, policy certificate(s) and riders) will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan, and will govern in the event they conflict with any benefits comparison, summary of coverage or other description of the plan.

The Applicant agrees to offer coverage to all eligible employees and that only those employees or former employees and their spouses or dependants who are eligible for coverage will be enrolled.

By signing below, you are signing the group application on behalf of the group applying for coverage and stating that (1) I am the Applicant or the agent for the Applicant and am authorized to sign this Group Application and (2) the Applicant will be legally bound by the terms and conditions of the application, this authorization and the plan documents.

Please note, that to the extent permitted by applicable State law, an employee's or employer's failure to pay any past-due premium amounts owed for coverage to Oxford or any of its affiliates to whom you are applying for coverage, or any other health insurance company within this health insurer's control group to whom you owe premium, within the past 12 months preceding the requested effective date of any new coverage, will be assigned to the employee's or employer's initial premium payment to effectuate new coverage.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 dollars and the stated value of the claim for each violation.**

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

**Full legal name of firm:** \_\_\_\_\_

Print Name of Authorized Company Representative

**X**

Signature of Authorized Company Representative

Title

Witness

Duly Licensed Resident Agent/Broker