Connecticut Small Group Application – OHI

Oxford Health Insurance, Inc.

Mailing Address: 14 Central Park Drive, Hooksett, NH 03106

I. General information

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

2. **Address of company:**
(Street Address
City, State, ZIP Code)
***Please - Do not use a PO Box.)**

3. **Plan Administrator/Contact:**
   a. Name and Title:
   b. Address:
   c. Phone Number: Area Code
   d. Fax Number: Area Code
   e. Email Address:

4. **Name and title of person to receive correspondence/billing statements:**
   a. Name:
   b. Title:
   c. Address:
   d. Phone Number: Area Code
   e. Fax Number: Area Code

5. **Full legal name and address of each subsidiary and/or affiliated company, branch or satellite office whose employees are to be covered:**

6. **Nature of business:**

7. **SIC Code filed with the State of CT:**

I. General information (continued)

8. **Type of Organization:** ☐ Corporation ☐ Partnership ☐ LLC ☐ LLP ☐ Other _____
Did you have any employees other than yourself and your spouse during the preceding calendar year? ☐ Yes ☐ No

9. **Tax Identification Code or Number:** Federal I.D. _____

10. **Did your group employ at least 1 but no more than 50 employees for at least 50% of your business days during the preceding 12 months?** ☐ Yes ☐ No

11. **Enter the Prior Calendar Year Average Total Number of Employees** _____

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

To calculate the annual average, add all the monthly employee totals together, then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

12. **Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees** _____

For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year. In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.

13. **Subject to ERISA?** ☐ Yes ☐ No (Most private sector plans are ERISA plans)

If No, please indicate appropriate category:

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

14. **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)
☐ Governmental
☐ Multiple Employer Welfare Arrangement (MEWA)
☐ Church
☐ Taft Hartley Union
☐ Employer Association

15. **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

16. **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

17. **Do you have common ownership with any other businesses?** ☐ Yes ☐ No If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

18. **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 in section II).

☐ 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

The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate.

1. **Effective date:** We request that this coverage be effective as of the first day of _____.
(Month/Year)

2. **Anniversary date:** The anniversary date will fall annually on the first day of the calendar month of the approved effective date.

3. **Other group health or individual coverage:** Any other health coverage (including Medicare) while enrolled with Oxford should be indicated on the individual Member Enrollment Forms.

   Please Note: Do not cancel existing coverage until you have received acceptance of this coverage by Underwriting.

   If no previous coverage, initial here _____.

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

4. **Employer Contributions:** Toward Employee Premium:_____%
   Toward Family Premium:_____%

5. **Eligibility and Termination:** Each employee must be eligible on the date the insurance provided under the Certificate becomes effective with respect to him/her. If the employee is not eligible for coverage on the date the Certificate becomes effective, the employee must wait until he/she is eligible for coverage.

   a) **Employee Eligibility:**
   Full-time Employees: ☐ Please check here to confirm that all permanent full-time employees work a minimum 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: ☐ Covered ☐ Not Covered

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

Indicate number of months or days, whichever is applicable, in the space provided below. Waiting period cannot exceed 90 days. In (i) below, if there is no waiting period, insert "O" 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

Definition of Class I _____

_____

i) Eligibility/Termination

☐ Date on which the employee completes _____days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

ii) Eligibility/Termination

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

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

iii) Waiting Period for Rehires

Waiting Period Waived for Rehires? ☐ **Yes** ☐ **No**

If yes, waived if rehired within _____ months.

CLASS II

Definition of Class II _____

_____

i) Eligibility/Termination

☐ Date on which the employee completes _____days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

ii) Eligibility/Termination

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

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

iii) Waiting Period for Rehires

Waiting Period Waived for Rehires? ☐ **Yes** ☐ **No**

If yes, waived if rehired within _____ months.

CLASS III

Definition of Class III _____

_____

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.

CLASS IV

Definition of Class IV _____

_____

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.

CLASS V

Definition of Class V _____

_____

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.

CLASS VI

Definition of Class VI _____

_____

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.

6. Number of Total Employees on the Effective Date:

Full-time employees _____ Part-time employees _____ Retired employees _____

Of the total employees: Were 51% or more active eligible full-time employees working in Connecticut? _____

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 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 stepchild) of the insured or insured's spouse who is under the age of 26

Coverage for dependent children who have reached the limiting age ends on the group's policy anniversary date following the attainment of the limiting age.

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 provided proof of such incapacity and dependency is furnished to Oxford within thirty-one (31) days of the child 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 and plan designs

Please select a plan from section A, B, C OR D

A. Platinum Plans

Plan Name	☐ CT P FRDM NG 20/45/100 PPO 22	☐ CT P FRDM NG 20/45/1000/100 PPO 22
Network	Freedom	Freedom
Gatekeeper	N	N
Copayment		
PCP	$20	$20
Specialist	$45	$45
Virtual Visit	100%	100%
Network Deductible (Single)	N/A	$1,000
Network Deductible (Family)	N/A	$2,000
Network Maximum Out of Pocket (Single)	$4,000	$4,000
Network Maximum Out of Pocket (Family)	$8,000	$8,000
Network Coinsurance	100%	100%
Outpatient Facility		
Freestanding	$350	100% after ded.
Hospital	$350	100% after ded.
Inpatient Facility	$750	100% after ded.
Emergency Room	$300	$300
Out of Network Deductible (Single)	$4,000	$4,000
Out of Network Deductible (Family)	$8,000	$8,000
Out of Network Maximum Out of Pocket (Single)	$8,000	$8,000
Out of Network Maximum Out of Pocket (Family)	$16,000	$16,000
Out of Network Coinsurance	80%	80%
Prescription Drug	$5/$60/50% to $500/50% to $750	$5/$60/50% to $500/50% to $750

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

Additional Benefit Options:

☐ **Domestic Partner**

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

B. Gold Plans

Plan Name	☐ CT G FRDM NG 25/60/1500/100 PPO 22	☐ CT G FRDM NG 25/60/2000/100 PPO 22	☐ CT G FRDM NG 25/60/3000/80 PPO 22	☐ CT G FRDM NG 25/60/3500/100 PPO 22
Network	Freedom	Freedom	Freedom	Freedom
Gatekeeper	N	N	N	N
Copayment				
PCP	$25	$25	$25	$25
Specialist	$60	$60	$60	$60
Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$1,500	$2,000	$3,000	$3,500
Network Deductible (Family)	$3,000	$4,000	$6,000	$7,000
Network Maximum Out of Pocket (Single)	$8,500	$6,500	$7,000	$7,250
Network Maximum Out of Pocket (Family)	$17,000	$13,000	$14,000	$14,500
Network Coinsurance	100%	100%	80%	100%
Outpatient Facility				
Freestanding	$500	$500	80% after ded.	$500 after ded.
Hospital	$500 after ded.	$500 after ded.	80% after ded.	100% after ded.
Inpatient Facility	100% after ded.	$750 after ded.	80% after ded.	100% after ded.
Emergency Room	$350	$350	80% after ded.	$350
Out of Network Deductible (Single)	$4,000	$5,000	$7,500	$7,500
Out of Network Deductible (Family)	$8,000	$10,000	$15,000	$15,000
Out of Network Maximum Out of Pocket (Single)	$15,000	$12,500	$15,000	$15,000
Out of Network Maximum Out of Pocket (Family)	$30,000	$25,000	$30,000	$30,000
Out of Network Coinsurance	80%	50%	50%	70%
Prescription Drug	$5/$60/50% to $500/50% to $750	$5/$60/50% to $500/50% to $750	$5/$60/50% to $500/50% to $750	$5/$60/50% to $500/50% to $750

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

Additional Benefit Options:

☐ **Domestic Partner**

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

B. Gold Plans (continued)

Plan Name	☐ CT G FRDM NG 25/60/4000/100 PPO 22	☐ CT G FRDM NG 30/50/5000/80 PPO 22	☐ CT G FRDM NG 2000/100 PPO HSA 22	☐ CT G FRDM NG 1500/90 PPO HSA 22
Network	Freedom	Freedom	Freedom	Freedom
Gatekeeper	N	N	N	N
Copayment				
PCP	$25	$30	100% after ded.	90% after ded.
Specialist	$60	$50	100% after ded.	90% after ded.
Virtual Visit	100%	100%	100% after ded.	90% after ded.
Network Deductible (Single)	$4,000	$5,000	$2,000	$1,500
Network Deductible (Family)	$8,000	$10,000	$4,000	$3,000
Network Maximum Out of Pocket (Single)	$7,500	$7,750	$6,950	$6,000
Network Maximum Out of Pocket (Family)	$15,000	$15,500	$13,900	$12,000
Network Coinsurance	100%	80%	100%	90%
Outpatient Facility				
Freestanding	100% after ded.	80% after ded.	100% after ded.	90% after ded.
Hospital	100% after ded.	80% after ded.	100% after ded.	90% after ded.
Inpatient Facility	100% after ded.	80% after ded.	100% after ded.	90% after ded.
Emergency Room	$350	$400	$350 after ded.	90% after ded.
Out of Network Deductible (Single)	$7,500	$9,000	$5,000	$5,000
Out of Network Deductible (Family)	$15,000	$18,000	$10,000	$10,000
Out of Network Maximum Out of Pocket (Single)	$15,000	$17,500	$10,000	$10,000
Out of Network Maximum Out of Pocket (Family)	$30,000	$35,000	$20,000	$20,000
Out of Network Coinsurance	70%	60%	70%	50%
Prescription Drug	$5/$60/50% to $500/50% to $750	$10/$60/50% to $500/50% to $750	Med ded then $10/$60/50% to $500/50% to $750	Med ded then $10/$60/50% to $500/50% to $750

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

Additional Benefit Options:

☐ **Domestic Partner**

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

B. Gold Plans (continued)

Plan Name	☐ CT G FRDM NG 25/70/2500/100 PPO 22	☐ CT G FRDM NG 30/50/4000/80 PPO 22
Network	Freedom	Freedom
Gatekeeper	N	N
Copayment		
PCP	$25	$30
Specialist	$70	$50
Virtual Visit	100%	100%
Network Deductible (Single)	$2,500	$4,000
Network Deductible (Family)	$5,000	$8,000
Network Maximum Out of Pocket (Single)	$8,700	$7,750
Network Maximum Out of Pocket (Family)	$17,400	$15,500
Network Coinsurance	100%	80%
Outpatient Facility		
Freestanding	100% after ded.	80% after ded.
Hospital	100% after ded.	80% after ded.
Inpatient Facility	100% after ded.	80% after ded.
Emergency Room	$400 after ded.	$400
Out of Network Deductible (Single)	$7,500	$9,000
Out of Network Deductible (Family)	$15,000	$18,000
Out of Network Maximum Out of Pocket (Single)	$15,000	$17,500
Out of Network Maximum Out of Pocket (Family)	$30,000	$35,000
Out of Network Coinsurance	50%	60%
Prescription Drug	$5/$60/50% to $500/50% to $750	$10/$60/50% to $500/50% to $750

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

Additional Benefit Options:

☐ **Domestic Partner**

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

C. Silver Plans

Plan Name	☐ CT S FRDM NG 30/75/5000/100 PPO 22	☐ CT S FRDM NG 30/70/5000/80 PPO 22	☐ CT S FRDM NG 30/75/5000/75 PPO 22	☐ CT S FRDM NG 30/75/6500/90 PPO 22
Network	Freedom	Freedom	Freedom	Freedom
Gatekeeper	N	N	N	N
Copayment				
PCP	$30	$30	$30	$30
Specialist	$75	$70	$75	$75
Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$5,000	$5,000	$5,000	$6,500
Network Deductible (Family)	$10,000	$10,000	$10,000	$13,000
Network Maximum Out of Pocket (Single)	$8,700	$8,500	$8,700	$8,700
Network Maximum Out of Pocket (Family)	$17,400	$17,000	$17,400	$17,400
Network Coinsurance	100%	80%	75%	90%
Outpatient Facility				
Freestanding	$500 after ded.	80% after ded.	75% after ded.	90% after ded.
Hospital	$500 after ded.	80% after ded.	75% after ded.	90% after ded.
Inpatient Facility	$750 after ded.	80% after ded.	75% after ded.	90% after ded.
Emergency Room	$350 after ded.	80% after ded.	75% after ded.	90% after ded.
Out of Network Deductible (Single)	$10,000	$10,000	$10,000	$10,000
Out of Network Deductible (Family)	$20,000	$20,000	$20,000	$20,000
Out of Network Maximum Out of Pocket (Single)	$15,000	$15,000	$20,000	$15,000
Out of Network Maximum Out of Pocket (Family)	$30,000	$30,000	$40,000	$30,000
Out of Network Coinsurance	50%	60%	50%	60%
Prescription Drug	$250 ded T3/T4 ded then $5/$60/50% to $500/50% to $750	$250 ded T3/T4 ded then $5/$60/50% to $500/50% to $750	$250 ded T3/T4 ded then $5/$60/50% to $500/50% to $750	$250 ded T3/T4 ded then $5/$60/50% to $500/50% to $750

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

Additional Benefit Options:

☐ **Domestic Partner**

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

C. Silver Plans (continued)

Plan Name	☐ CT S FRDM NG 35/75/7500/100 PPO 22	☐ CT S FRDM NG 3000/90 PPO HSA 22	☐ CT S FRDM NG 4000/100 PPO HSA 22	☐ CT S FRDM NG 3000/80 PPO HSA 22
Network	Freedom	Freedom	Freedom	Freedom
Gatekeeper	N	N	N	N
Copayment				
PCP	$35	90% after ded.	100% after ded.	80% after ded.
Specialist	$75	90% after ded.	100% after ded.	80% after ded.
Virtual Visit	100%	90% after ded.	100% after ded.	80% after ded.
Network Deductible (Single)	$7,500	$3,000	$4,000	$3,000
Network Deductible (Family)	$15,000	$6,000	$8,000	$6,000
Network Maximum Out of Pocket (Single)	$8,700	$6,950	$6,950	$6,950
Network Maximum Out of Pocket (Family)	$17,400	$13,900	$13,900	$13,900
Network Coinsurance	100%	90%	100%	80%
Outpatient Facility				
Freestanding	100% after ded.	90% after ded.	100% after ded.	80% after ded.
Hospital	100% after ded.	90% after ded.	100% after ded.	80% after ded.
Inpatient Facility	100% after ded.	90% after ded.	100% after ded.	80% after ded.
Emergency Room	100% after ded.	90% after ded.	$350 after ded.	80% after ded.
Out of Network Deductible (Single)	$14,000	$7,500	$10,000	$10,000
Out of Network Deductible (Family)	$28,000	$15,000	$20,000	$20,000
Out of Network Maximum Out of Pocket (Single)	$20,000	$15,000	$20,000	$20,000
Out of Network Maximum Out of Pocket (Family)	$40,000	$30,000	$40,000	$40,000
Out of Network Coinsurance	70%	50%	50%	50%
Prescription Drug	$10/$60/50% to $500/50% to $750	Med ded then $10/$60/50% to $500/50% to $750	Med ded then $10/$60/50% to $500/50% to $750	Med ded then $10/$60/50% to $500/50% to $750

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

Additional Benefit Options:

☐ **Domestic Partner**

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

C. Silver Plans (continued)

Plan Name	☐ CT S FRDM NG 20/75/6500/80 PPO PRO 22	☐ CT S FRDM NG 30/60/2500/100 PPO HSA 22
Network	Freedom	Freedom
Gatekeeper	N	N
Copayment		
PCP	$20	$30 after ded.
Specialist	$75	$60 after ded.
Virtual Visit	100%	100% after ded.
Network Deductible (Single)	$6,500	$2,500
Network Deductible (Family)	$13,000	$5,000
Network Maximum Out of Pocket (Single)	$8,700	$6,950
Network Maximum Out of Pocket (Family)	$17,400	$13,900
Network Coinsurance	80%	100%
Outpatient Facility		
Freestanding	80% after ded.	$300 after ded.
Hospital	80% after ded.	$600 after ded.
Inpatient Facility	80% after ded.	$500 after ded.
Emergency Room	50% after ded.	$350 after ded.
Out of Network Deductible (Single)	$10,000	$7,500
Out of Network Deductible (Family)	$20,000	$15,000
Out of Network Maximum Out of Pocket (Single)	$20,000	$15,000
Out of Network Maximum Out of Pocket (Family)	$40,000	$30,000
Out of Network Coinsurance	50%	70%
Prescription Drug	$250 ded T3/T4 ded then $5/$60/50% to $500/50% to $750	Med ded then $10/$60/50% to $500/50% to $750

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

Additional Benefit Options:

☐ **Domestic Partner**

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

D. Bronze Plans

Plan Name	☐ CT B FRDM NG 6000/50 PPO HSA 22	☐ CT B FRDM NG 6700/100 PPO HSA 22	☐ CT B FRDM NG 7000/70 PPO 22
Network	Freedom	Freedom	Freedom
Gatekeeper	N	N	N
Copayment			
PCP	50% after ded.	100% after ded.	70% after ded.
Specialist	50% after ded.	100% after ded.	70% after ded.
Virtual Visit	50% after ded.	100% after ded.	70% after ded.
Network Deductible (Single)	$6,000	$6,700	$7,000
Network Deductible (Family)	$12,000	$13,400	$14,000
Network Maximum Out of Pocket (Single)	$6,950	$6,950	$8,500
Network Maximum Out of Pocket (Family)	$13,900	$13,900	$17,000
Network Coinsurance	50%	100%	70%
Outpatient Facility			
Freestanding	50% after ded.	100% after ded.	70% after ded.
Hospital	50% after ded.	100% after ded.	70% after ded.
Inpatient Facility	50% after ded.	100% after ded.	70% after ded.
Emergency Room	50% after ded.	100% after ded.	70% after ded.
Out of Network Deductible (Single)	$10,000	$10,000	$10,000
Out of Network Deductible (Family)	$20,000	$20,000	$20,000
Out of Network Maximum Out of Pocket (Single)	$20,000	$20,000	$20,000
Out of Network Maximum Out of Pocket (Family)	$40,000	$40,000	$40,000
Out of Network Coinsurance	50%	70%	50%
Prescription Drug	Med ded then $10/$60/50% to $500/50% to $750	Med ded then $10/$60/50% to $500/50% to $750	$250 ded T3/T4 ded then $5/$60/50% to $500/50% to $750

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

Additional Benefit Options:

☐ **Domestic Partner**

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

IV. 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? _____

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:			

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 visit our website. 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 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.

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. 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.

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Applicant's employees. This consent remains in effect until it is withdrawn. The Applicant may withdraw their consent at any time or request a document in a paper or non-electronic form.

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

Print Name of Authorized Officer of the Applicant | Title of Officer of Applicant

X

Signature of Authorized Officer of the Applicant | Date

X

Duly Licensed and Appointed Producer* | Date

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