United Healthcare Oxford

New Jersey Application for a Small Employer Health Benefits Policy

Oxford Health Insurance, Inc. (OHI)

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

Please print or type

Policy Number (OHP Use Only): _____

☐ **New Policy** ☐ **Change in Policy**

Requested Effective Date: _____

* Note: The effective date will be on or after the date Oxford approves the application.

I. Policyholder information

1. **Policyholder (**Full legal name of company):

2. **Tax identification number:**

3. **Main address:**

Street

City State ZIP Code

Mailing address:

Street

City State ZIP Code

Fax

Telephone & Facsimile:

Email Address: _____

Contract information should be provided ☐ **electronically or** ☐ **hard copy. Check one.**

Monthly invoices should be provided ☐ **electronically (through the Group Portal) or** ☐ **hard copy. Check one.**

4. **Name of correspondent:**

5. **Type of organization:** ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain) _____

6. **Nature of business (specify):** _____ **SIC Code:** _____

7. **Number of full-time employees in your company:** _____

Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.

8. **Number of full-time employees to be insured:** _____

9. **Class or classes to be excluded:** _____

10. **Insurance requested for:** ☐ Employees Only ☐ Employees and Dependents excluding Spouse
☐ Employees and Dependents including Spouse

Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c.246 ☐ Yes ☐ No

If yes, should the plan provide coverage for children of a covered domestic partner? ☐ Yes ☐ No

11. **Is the employer subject to the requirements of COBRA?** ☐ Yes ☐ No

12. **Is the employer subject to the requirements of Medicare as Secondary Payer rules for eligibility due to age?**
☐ Yes ☐ No
Due to disability? ☐ Yes ☐ No

I. Policyholder information (continued)

13. Orientation Period: ☐ Yes ☐ No

14. Waiting period before employees become insured (may not exceed 90 days):

Present employees _____ New or rehired employees _____

15. Period for Annual Employee Open Enrollment Period: _____

16. What percentage of the premium will the employer pay? _____

17. Deposit $ _____ **Premium Paid:** ☐ Monthly ☐ Quarterly

Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (must be included for purposes of participation)

Legal name and location	Number of full-time employees in this company	Number of full-time employees to be insured

II. Specifications for coverage

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

A. Platinum Plans

Plan Name	☐ NJ P FRDM NG 20/40/100 PPO 22	☐ NJ P FRDM NG 15/40/100 EPO 22	☐ NJ P LBTY NG 15/40/100 EPO 22	☐ NJ P LBTY NG 15/45/100 PPO 22
Network	Freedom	Freedom	Liberty	Liberty
Gatekeeper	N	N	N	N
Copayment				
PCP	$20	$15	$15	$15
Specialist	$40	$40	$40	$45
Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	N/A	N/A	N/A	N/A
Network Deductible (Family)	N/A	N/A	N/A	N/A
Network Maximum Out of Pocket (Single)	$3,500	$3,500	$3,500	$3,500
Network Maximum Out of Pocket (Family)	$7,000	$7,000	$7,000	$7,000
Network Coinsurance	100%	100%	100%	100%
Outpatient Facility				
Freestanding	$10	$10	$10	$10
Hospital	$500	$500	$500	$500
Inpatient Facility per day	$200	$250	$300	$300
Inpatient max per admit	$1,000	$1,250	$1,500	$1,500
Emergency Room	$100	$100	$100	$100
Emergency Room Per Occurrence Copay	$100	$100	$100	$100
Out of Network Deductible (Single)	$3,000	N/A	N/A	$3,000
Out of Network Deductible (Family)	$6,000	N/A	N/A	$6,000
Out of Network Maximum Out of Pocket (Single)	$7,500	N/A	N/A	$7,500
Out of Network Maximum Out of Pocket (Family)	$15,000	N/A	N/A	$15,000
Out of Network Coinsurance	70%	N/A	N/A	70%
Prescription Drug (Mail Order is 2x retail amount)	$5/$25/$50 SpRx:$5/20% to $150/50% to $150	$5/$25/$50 SpRx:$5/20% to $150/50% to $150	$5/$25/$50 SpRx:$5/20% to $150/50% to $500	$5/$25/$50 SpRx:$5/20% to $150/50% to $500

II. Specifications for coverage (continued)

A. Platinum Plans (continued)

Plan Name	☐ NJ P MTRO NG 10/40/100 EPO 22	☐ NJ P MTRO GT 5/75/100 EPO 22
Network	Metro	Metro
Gatekeeper	N	Y
Copayment		
PCP	$10	$5
Specialist	$40	$75
Virtual Visit	100%	100%
Network Deductible (Single)	N/A	N/A
Network Deductible (Family)	N/A	N/A
Network Maximum Out of Pocket (Single)	$3,500	$3,500
Network Maximum Out of Pocket (Family)	$7,000	$7,000
Network Coinsurance	100%	100%
Outpatient Facility		
Freestanding	$10	$10
Hospital	$500	50%
Inpatient Facility per day	$200	$500
Inpatient max per admit	$400	$2,500
Emergency Room	$100	50%
Emergency Room Per Occurrence Copay	$100	N/A
Out of Network Deductible (Single)	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A
Out of Network Coinsurance	N/A	N/A
Prescription Drug (Mail Order is 2x retail amount)	$100D T2/3 $5/$35/$60 SpRx:$5/20% to $150/50% to $150	$100D T2/3 $5/$25/$60 SpRx:$5/20% to $150/50% to $150

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	☐ NJ G FRDM NG 30/75/1500/80 PPO 22	☐ NJ G FRDM NG 50/50/1000/100 EPO 22	☐ NJ G FRDM NG 25/60/1000/80 PPO 22	☐ NJ G LBTY NG 50/50/1000/100 EPO 22
Network	Freedom	Freedom	Freedom	Liberty
Gatekeeper	N	N	N	N
Copayment				
PCP	$30	$50	$25	$50
Specialist	$75	$50	$60	$50
Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$1,500	$1,000	$1,000	$1,000
Network Deductible (Family)	$3,000	$2,000	$2,000	$2,000
Network Maximum Out of Pocket (Single)	$5,000	$6,000	$5,500	$6,000
Network Maximum Out of Pocket (Family)	$10,000	$12,000	$11,000	$12,000
Network Coinsurance	80%	100%	80%	100%
Outpatient Facility				
Freestanding	$100	$100	$100 after ded	$100
Hospital	50% after ded	50% after ded	50% after ded	50% after ded
Inpatient Facility per day	80% after ded	$500	80% after ded	$500
Inpatient max per admit	N/A	$2,500	N/A	$2,500
Emergency Room	50% after ded	50% after ded	50% after ded	50% after ded
Emergency Room Per Occurrence Copay	$100	$100	$100	$100
Out of Network Deductible (Single)	$4,000	N/A	$3,000	N/A
Out of Network Deductible (Family)	$8,000	N/A	$6,000	N/A
Out of Network Maximum Out of Pocket (Single)	$9,000	N/A	$7,500	N/A
Out of Network Maximum Out of Pocket (Family)	$18,000	N/A	$15,000	N/A
Out of Network Coinsurance	60%	N/A	60%	N/A
Prescription Drug (Mail Order is 2x retail amount)	$100D T2/3 $5/$35/$75 SpRx:$5/20% to $150/50% to $150	$100D T2/3 $5/$35/$75 SpRx:$5/20% to $150/50% to $150	$100D T2/3 $5/$35/$75 SpRx:$5/20% to $150/50% to $150	$100D T2/3 $5/$35/$75 SpRx:$5/20% to $150/50% to $150

B. Gold Plans (continued)

Plan Name	☐ NJ G LBTY NG 25/50/1000/50 EPO 22	☐ NJ G LBTY GT 50/50/1000/100 EPO 22	☐ NJ G LBTY NG 35/60/2000/70 PPO 22	☐ NJ G LBTY NG 25/60/1500/70 EPO 22
Network	Liberty	Liberty	Liberty	Liberty
Gatekeeper	N	Y	N	N
Copayment				
PCP	$25	$50	$35	$25
Specialist	$50	$50	$60	$60
Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$1,000	$1,000	$2,000	$1,500
Network Deductible (Family)	$2,000	$2,000	$4,000	$3,000
Network Maximum Out of Pocket (Single)	$5,000	$6,000	$7,500	$5,500
Network Maximum Out of Pocket (Family)	$10,000	$12,000	$15,000	$11,000
Network Coinsurance	50%	100%	70%	70%
Outpatient Facility				
Freestanding	$100	$100	70% after ded	70% after ded
Hospital	50% after ded	50% after ded	70% after ded	70% after ded
Inpatient Facility per day	50% after ded	$500	70% after ded	70% after ded
Inpatient max per admit	N/A	$2,500	N/A	N/A
Emergency Room	50% after ded	50% after ded	50% after ded	50% after ded
Emergency Room Per Occurrence Copay	$100	$100	$100	$100
Out of Network Deductible (Single)	N/A	N/A	$4,500	N/A
Out of Network Deductible (Family)	N/A	N/A	$9,000	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	$10,000	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	$20,000	N/A
Out of Network Coinsurance	N/A	N/A	50%	N/A
Prescription Drug (Mail Order is 2x retail amount)	$100D T2/3 $5/$35/$75 SpRx:$5/20% to $150/50% to $150	$100D T2/3 $5/$35/$75 SpRx:$5/20% to $150/50% to $150	$75D T2/3 $5/$35/$75 SpRx:$5/20% to $150/50% to $500	$100D $5/$35/$75 SpRx:$5/20% to $150/50% to $500

B. Gold Plans (continued)

Plan Name	☐ NJ G LBTY NG 1500/90 EPO HSAM 22	☐ NJ G LBTY GT 15/75/1000/50 EPO 22	☐ NJ G LBTY NG 30/65/1500/80 PPO 22	☐ NJ G LBTY NG 25/60/1500/80 EPO 22
Network	Liberty	Liberty	Liberty	Liberty
Gatekeeper	N	Y	N	N
Copayment				
PCP	90% after ded	$15	$30	$25
Specialist	90% after ded	$75	$65	$60
Virtual Visit	100% after ded	100%	100%	100%
Network Deductible (Single)	$1,500	$1,000	$1,500	$1,500
Network Deductible (Family)	$3,000	$2,000	$3,000	$3,000
Network Maximum Out of Pocket (Single)	$5,000	$8,700	$5,500	$5,000
Network Maximum Out of Pocket (Family)	$10,000	$17,400	$11,000	$10,000
Network Coinsurance	90%	50%	80%	80%
Outpatient Facility				
Freestanding	90% after ded	$100	$100	$100
Hospital	90% after ded	50% after ded	50% after ded	50% after ded
Inpatient Facility per day	90% after ded	50% after ded	80% after ded	80% after ded
Inpatient max per admit	N/A	N/A	N/A	N/A
Emergency Room	50% after ded	50% after ded	50% after ded	50% after ded
Emergency Room Per Occurrence Copay	$100	$100	$100	$100
Out of Network Deductible (Single)	N/A	N/A	$4,000	N/A
Out of Network Deductible (Family)	N/A	N/A	$8,000	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	$9,000	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	$18,000	N/A
Out of Network Coinsurance	N/A	N/A	60%	N/A
Prescription Drug (Mail Order is 2x retail amount)	$5/$50/50% SpRx:$5/20% to $150/50% to $500	$100D $5/$35/$75 SpRx:$5/20% to $150/50% to $500	$75D T2/3 $5/$35/$75 SpRx:$5/20% to $150/50% to $500	$75D T2/3 $5/$35/$75 SpRx:$5/20% to $150/50% to $500

B. Gold Plans (continued)

Plan Name	☐ NJ G LBTY NG 30/50/2000/50 EPO 22	☐ NJ G LBTY NG 30/75/1500/80 EPO 22	☐ NJ G MTRO NG 30/60/2000/70 EPO 22	☐ NJ G MTRO GT 25/75/1250/80 EPO 22
Network	Liberty	Liberty	Metro	Metro
Gatekeeper	N	N	N	Y
Copayment				
PCP	$30	$30	$30	$25
Specialist	$50	$75	$60	$75
Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$2,000	$1,500	$2,000	$1,250
Network Deductible (Family)	$4,000	$3,000	$4,000	$2,500
Network Maximum Out of Pocket (Single)	$6,000	$5,500	$7,000	$6,000
Network Maximum Out of Pocket (Family)	$12,000	$11,000	$14,000	$12,000
Network Coinsurance	50%	80%	70%	80%
Outpatient Facility				
Freestanding	50% after ded	80% after ded	70% after ded	$200 after ded
Hospital	50% after ded	50% after ded	70% after ded	50% after ded
Inpatient Facility per day	50% after ded	80% after ded	70% after ded	80% after ded
Inpatient max per admit	N/A	N/A	N/A	N/A
Emergency Room	50% after ded	50% after ded	50% after ded	50% after ded
Emergency Room Per Occurrence Copay	$100	$100	$100	$100
Out of Network Deductible (Single)	N/A	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug (Mail Order is 2x retail amount)	$75D T2/3 $5/$35/$75 SpRx:$5/20% to $150/50% to $500	$75D T2/3 $5/$35/$75 SpRx:$5/20% to $150/50% to $500	$100 Ded. T2/T3 then $10/$40/50% SpRx:$10/20% to $150/50% to $500	$100D T2/3 $5/$25/$60 SpRx:$5/20% to $150/50% to $150

B. Gold Plans (continued)

Plan Name	☐ NJ G MTRO NG 2000/100 EPO HSAM 22	☐ NJ G MTRO NG 25/50/1000/50 EPO 22	☐ NJ G MTRO NG 2000/100 EPO HSA 22	☐ NJ G MTRO NG 25/60/1500/80 EPO 22
Network	Metro	Metro	Metro	Metro
Gatekeeper	N	N	N	N
Copayment				
PCP	100% after ded	$25	100% after ded	$25
Specialist	100% after ded	$50	100% after ded	$60
Virtual Visit	100% after ded	100%	100% after ded	100%
Network Deductible (Single)	$2,000	$1,000	$2,000	$1,500
Network Deductible (Family)	$4,000	$2,000	$4,000	$3,000
Network Maximum Out of Pocket (Single)	$6,000	$5,000	$6,000	$5,000
Network Maximum Out of Pocket (Family)	$12,000	$10,000	$12,000	$10,000
Network Coinsurance	100%	50%	100%	80%
Outpatient Facility				
Freestanding	100% after ded	$100	100% after ded	$100
Hospital	100% after ded	50% after ded	100% after ded	50% after ded
Inpatient Facility per day	100% after ded	50% after ded	100% after ded	80% after ded
Inpatient max per admit	N/A	N/A	N/A	N/A
Emergency Room	50% after ded	50% after ded	50% after ded	50% after ded
Emergency Room Per Occurrence Copay	$100	$100	$100	$100
Out of Network Deductible (Single)	N/A	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug (Mail Order is 2x retail amount)	$10/$40/50% SpRx:$10/20% to $150/50% to $500	$100DT2/T3 then $10/$40/50% SpRx:$10/20% to $150/50% to $500	$10/$40/50% SpRx:$10/20% to $150/50% to $500	$100D T2/T3 then $10/$40/50% SpRx:$10/20% to $150/50% to $500

B. Gold Plans (continued)

Plan Name	☐ NJ G MTRO GT 5/75/2000/50 EPO 22
Network	Metro
Gatekeeper	Y
Copayment	
PCP	$5
Specialist	$75
Virtual Visit	100%
Network Deductible (Single)	$2,000
Network Deductible (Family)	$4,000
Network Maximum Out of Pocket (Single)	$8,000
Network Maximum Out of Pocket (Family)	$16,000
Network Coinsurance	50%
Outpatient Facility	
Freestanding	$500
Hospital	$500 after ded
Inpatient Facility per day	50% after ded
Inpatient max per admit	N/A
Emergency Room	50% after ded
Emergency Room Per Occurrence Copay	N/A
Out of Network Deductible (Single)	N/A
Out of Network Deductible (Family)	N/A
Out of Network Maximum Out of Pocket (Single)	N/A
Out of Network Maximum Out of Pocket (Family)	N/A
Out of Network Coinsurance	N/A
Prescription Drug (Mail Order is 2x retail amount)	$100D $5/$25/$60 SpRx:$5/20% to $150/50% to $150

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)

II. Specifications for coverage (continued)

C. Silver Plans

Plan Name	☐ NJ S FRDM NG 50/75/2500/60 PPO 22	☐ NJ S FRDM NG 2500/100 PPO HSA 22	☐ NJ S LBTY NG 20/40/2000/60 PPO HSA 22	☐ NJ S LBTY NG 40/75/2500/50 EPO 22
Network	Freedom	Freedom	Liberty	Liberty
Gatekeeper	N	N	N	N
Copayment				
PCP	$50	100% after ded	$20 after ded	$40
Specialist	$75	100% after ded	$40 after ded	$75
Virtual Visit	100%	100% after ded	100% after ded	100%
Network Deductible (Single)	$2,500	$2,500	$2,000	$2,500
Network Deductible (Family)	$5,000	$5,000	$4,000	$5,000
Network Maximum Out of Pocket (Single)	$8,700	$7,000	$6,000	$8,550
Network Maximum Out of Pocket (Family)	$17,400	$14,000	$12,000	$17,100
Network Coinsurance	60%	100%	60%	50%
Outpatient Facility				
Freestanding	$250 after ded	100% after ded	$250 after ded	$250 after ded
Hospital	50% after ded	50% after ded	50% after ded	50% after ded
Inpatient Facility per day	60% after ded	$500 after ded	60% after ded	50% after ded
Inpatient max per admit	N/A	$2,500	N/A	N/A
Emergency Room	50% after ded	50% after ded	50% after ded	50% after ded
Emergency Room Per Occurrence Copay	$100	$100	$100	$100
Out of Network Deductible (Single)	$5,000	$5,000	$4,000	N/A
Out of Network Deductible (Family)	$10,000	$10,000	$8,000	N/A
Out of Network Maximum Out of Pocket (Single)	$12,500	$13,700	$8,000	N/A
Out of Network Maximum Out of Pocket (Family)	$25,000	$27,400	$16,000	N/A
Out of Network Coinsurance	50%	50%	50%	N/A
Prescription Drug (Mail Order is 2x retail amount)	$100D T2/3 $5/$50/50% SpRx:$5/20% to $150/50% to $150	$5/$50/50% SpRx:$5/20% to $150/50% to $150	$5/$50/50% SpRx:$5/20% to $150/50% to $500	$250D T2/3 $5/$50/50% SpRx:$5/20% to $150/50% to $500

C. Silver Plans (continued)

Plan Name	☐ NJ S LBTY NG 50/75/2500/60 PPO 22	☐ NJ S LBTY NG 2500/80 EPO HSAM 22	☐ NJ S LBTY NG 30/50/2000/80 EPO HSA 22	☐ NJ S LBTY GT 30/75/2500/50 EPO 22
Network	Liberty	Liberty	Liberty	Liberty
Gatekeeper	N	N	N	Y
Copayment				
PCP	$50	80% after ded	$30 after ded	$30 after ded
Specialist	$75	80% after ded	$50 after ded	$75 after ded
Virtual Visit	100%	100% after ded	100% after ded	100%
Network Deductible (Single)	$2,500	$2,500	$2,000	$2,500
Network Deductible (Family)	$5,000	$5,000	$4,000	$5,000
Network Maximum Out of Pocket (Single)	$8,700	$7,000	$7,000	$8,700
Network Maximum Out of Pocket (Family)	$17,400	$14,000	$14,000	$17,400
Network Coinsurance	60%	80%	80%	50%
Outpatient Facility				
Freestanding	$250 after ded	80% after ded	$250 after ded	$100 after ded
Hospital	50% after ded	80% after ded	50% after ded	50% after ded
Inpatient Facility per day	60% after ded	80% after ded	80% after ded	50% after ded
Inpatient max per admit	N/A	N/A	N/A	N/A
Emergency Room	50% after ded	50% after ded	50% after ded	50% after ded
Emergency Room Per Occurrence Copay	$100	$100	$100	$100
Out of Network Deductible (Single)	$5,000	N/A	N/A	N/A
Out of Network Deductible (Family)	$10,000	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	$12,500	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	$25,000	N/A	N/A	N/A
Out of Network Coinsurance	50%	N/A	N/A	N/A
Prescription Drug (Mail Order is 2x retail amount)	$250D T2/3 $5/$50/50% SpRx:$5/20% to $150/50% to $500	$5/$50/50% SpRx:$5/20% to $150/50% to $500	$5/$50/50% SpRx:$5/20% to $150/50% to $500	$250D T2/3 $5/$50/50% SpRx:$5/20% to $150/50% to $500

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	☐ NJ S MTRO NG 50/75/2500/60 EPO 22	☐ NJ S MTRO GT 30/60/2500/80 EPO 22	☐ NJ S MTRO GT 35/50/2500/70 EPO HSA 22	☐ NJ S MTRO NG 40/75/2500/50 EPO 22
Network	Metro	Metro	Metro	Metro
Gatekeeper	N	Y	Y	N
Copayment				
PCP	$50	$30 after ded	$35 after ded	$40
Specialist	$75	$60 after ded	$50 after ded	$75
Virtual Visit	100%	100% after ded	100% after ded	100%
Network Deductible (Single)	$2,500	$2,500	$2,500	$2,500
Network Deductible (Family)	$5,000	$5,000	$5,000	$5,000
Network Maximum Out of Pocket (Single)	$8,700	$8,700	$7,050	$8,550
Network Maximum Out of Pocket (Family)	$17,400	$17,400	$14,100	$17,100
Network Coinsurance	60%	80%	70%	50%
Outpatient Facility				
Freestanding	$250 after ded	$250 after ded	$300 after ded	$250 after ded
Hospital	50% after ded	50% after ded	70% after ded	50% after ded
Inpatient Facility per day	60% after ded	$500 after ded	70% after ded	50% after ded
Inpatient max per admit	N/A	$2,500	N/A	N/A
Emergency Room	50% after ded	50% after ded	50% after ded	50% after ded
Emergency Room Per Occurrence Copay	$100	$100	$100	$100
Out of Network Deductible (Single)	N/A	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug (Mail Order is 2x retail amount)	$100D T2/T3 $5/$50/50% SpRx:$5/20% to $150/50% to $150	$250D T2/3 $5/$50/50% SpRx:$5/20% to $150/50% to $500	$5/$50/50% SpRx:$5/20% to $150/50% to $500	$100D T2/T3 $5/$50/50% SpRx:$5/20% to $150/50% to $150

C. Silver Plans (continued)

Plan Name	☐ NJ S MTRO NG 25/50/2000/80 EPO HSA 22
Network	Metro
Gatekeeper	N
Copayment	
PCP	$25 after ded
Specialist	$50 after ded
Virtual Visit	100% after ded
Network Deductible (Single)	$2,000
Network Deductible (Family)	$4,000
Network Maximum Out of Pocket (Single)	$7,000
Network Maximum Out of Pocket (Family)	$14,000
Network Coinsurance	80%
Outpatient Facility	
Freestanding	$250 after ded
Hospital	$500 after ded
Inpatient Facility per day	$500 after ded
Inpatient max per admit	N/A
Emergency Room	50% after ded
Emergency Room Per Occurrence Copay	$100
Out of Network Deductible (Single)	N/A
Out of Network Deductible (Family)	N/A
Out of Network Maximum Out of Pocket (Single)	N/A
Out of Network Maximum Out of Pocket (Family)	N/A
Out of Network Coinsurance	N/A
Prescription Drug (Mail Order is 2x retail amount)	$5/$50/50% SpRx:$5/20% to $150/50% to $500

II. Specifications for coverage (continued)

D. Bronze Plans

Plan Name	☐ NJ B LBTY NG 10/70/6000/50 EPO HSA 22	☐ NJ B LBTY NG 5900/50 EPO HSA 22	☐ NJ B MTRO NG 5900/50 EPO HSA 22	☐ NJ B MTRO NG 10/70/6000/50 EPO HSA 22
Network	Liberty	Liberty	Metro	Metro
Gatekeeper	N	N	N	N
Copayment				
PCP	$10 after ded	50% after ded	50% after ded	$10 after ded
Specialist	$70 after ded	50% after ded	50% after ded	$70 after ded
Virtual Visit	100% after ded	100% after ded	100% after ded	100% after ded
Network Deductible (Single)	$6,000	$5,900	$5,900	$6,000
Network Deductible (Family)	$12,000	$11,800	$11,800	$12,000
Network Maximum Out of Pocket (Single)	$6,900	$6,900	$6,900	$6,900
Network Maximum Out of Pocket (Family)	$13,800	$13,800	$13,800	$13,800
Network Coinsurance	50%	50%	50%	50%
Outpatient Facility				
Freestanding	50% after ded	50% after ded	50% after ded	50% after ded
Hospital	50% after ded	50% after ded	50% after ded	50% after ded
Inpatient Facility per day	$50 after ded	$100 after ded	$100 after ded	$50 after ded
Inpatient max per admit	$250	$500	$500	$250
Emergency Room	50% after ded	50% after ded	50% after ded	50% after ded
Emergency Room Per Occurrence Copay	$100	$100	$100	$100
Out of Network Deductible (Single)	N/A	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug (Mail Order is 2x retail amount)	Comb Med/ Rx ded. then 50% to $150	Comb Med/ Rx ded. then 50% to $150	Comb Med/ Rx ded. then 50%	Comb Med/ Rx ded. then 50% to $250

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)

III. All questions must be answered

1. Is there any Group Health Plan:
   Now in force and to be continued? ☐ Yes ☐ No
   Currently being applied for? ☐ Yes ☐ No

   If "yes," identify the name of the Group Health Plan, give a description of the plan(s) and the name of insurance carrier(s):

   _____

2. Name of present or prior group carrier: _____

   Effective date of prior coverage:_____ Cancellation/termination date:_____

   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No

   If "yes," give reason: _____

   Plan being replaced: _____

3. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

4. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

   Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/ Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start	End

   If additional space is needed, attach a separate sheet, signed and dated.

5. To the best of your knowledge:
   A. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   B. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

   Additional space to explain if Items 1, 2 or 3 were answered "yes." Refer to the question number, and give details including names, where appropriate.

   _____

   _____

   _____

6. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No

   (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

IV. Agent/producer information

Broker _____ _____
Name Code Address

Broker _____ _____
Name Code Address

V. Signature

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. (Refer to the definition on the New Jersey Employer Certification.) It is further understood that no agent has power on behalf of Oxford to make or modify any request or application for insurance or to bind Oxford by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Oxford. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

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

Dated at:_____on_____

_____ _____

Print name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

_____

Witness to Signature

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.