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New York Small Group Application – OHI

Oxford Health Insurance Inc. ▪ www.oxfordhealth.com
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):**

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-subsidiary 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 5/15/100 EPO 19	❑ NY P FRDM NG 20/40/100 EPO 19
Network	Freedom	Freedom
Copayment: **a. PCP** **b. Specialist**	 $5 per visit $15 per visit	 $20 per visit $40 per visit
In-Network Deductible (Single/Family)	N/A	N/A
In-Network Maximum Out-of-Pocket (Single/Family)	$2,500/$5,000	$2,500/$5,000
In-Network Coinsurance	N/A	N/A
Outpatient Facility Copayment	Freestanding Facility – $50 Hospital Facility – $100	Freestanding Facility – $100 Hospital Facility – $300
Inpatient Facility Copayment	$200 per admission	$400 per admission
Emergency Room	$200	$200
Prescription Drug Coverage	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible – $50**	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible – $50**

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Platinum Plans (Continued)

Option	❑ NY P FRDM NG 5/15/100 PPO 19	❑ NY P FRDM NG 20/40/100 PPO 19	❑ NY P FRDM NG 20/40/100 PPO FAIR 19
Network	Freedom	Freedom	Freedom
Copayment: **a. PCP** **b. Specialist**	 $5 per visit $15 per visit	 $20 per visit $40 per visit	 $20 per visit $40 per visit
In-Network Deductible (Single/Family)	N/A	N/A	N/A
In-Network Maximum Out-of-Pocket (Single/Family)	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000
In-Network Coinsurance	N/A	N/A	N/A
Outpatient Facility Copayment	Freestanding Facility – $50 Hospital Facility – $100	Freestanding Facility – $100 Hospital Facility – $300	Freestanding Facility – $100 Hospital Facility – $300
Inpatient Facility Copayment	$200 per admission	$400 per admission	$400 per admission
Emergency Room	$200	$200	$200
Out-of-Network Deductible (Single/Family)	$2,000/$4,000	$3,000/$6,000	$3,000/$6,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	$5,000/$10,000	$7,500/$15,000	$7,500/$15,000
Out-of-Network Coinsurance	30%	30%	20%
Out-of-Network Reimbursement	140% MNRP	140% MNRP	80% FAIR* * *
Prescription Drug Coverage	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible - $50 * *	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible - $50 * *	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible - $50 * *

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

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

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)

Platinum Plans (Continued)

Option	❑ NY P LBTY GT 15/35/250/90 EPO LA 19	❑ NY P FRDM NG 10/30/500/90 EPO 19
Network	Liberty	Freedom
Access	Gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $15 per visit $35 per visit	 $10 per visit $30 per visit
In-Network Deductible (Single/Family)	$250/$500	$500/$1,000
In-Network Maximum Out-of-Pocket (Single/Family)	$3,000/$6,000	$4000/$8000
In-Network Coinsurance	10%	10%
Outpatient Facility Copayment	Freestanding Facility – 10% after deductible Hospital Facility – 10% after deductible	Freestanding Facility – $150 after deductible Hospital Facility – $300 after deductible
Inpatient Facility Copayment	10% after deductible	10% after deductible
Emergency Room	10% after deductible	$200
Out-of-Network Deductible (Single/Family)	N/A	N/A
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	N/A
Out-of-Network Coinsurance	N/A	N/A
Prescription Drug Coverage	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment $150 rx deductible** Mail-Order - 2.5x copay	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment $50 rx deductible** Mail-Order - 2.5x copay

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

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

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	❑ NY G FRDM NG 15/35/1000/90 EPO 19	❑ NY G FRDM NG 25/40/1250/80 EPO 19	❑ NY G FRDM NG 1500/90 EPO HSA 19	❑ NY G FRDM NG 50/50/750/90 EPO 19
Network	Freedom	Freedom	Freedom	Freedom
Copayment: **a. PCP** **b. Specialist**	 $15 per visit $35 per visit	 $25 per visit $40 per visit	 10% after deductible 10% after deductible	 $50 per visit $50 per visit
In-Network Deductible (Single/Family)	$1,000/$2,000	$1,250/$2,500	$1,500/$3,000	$750/$1,500
In-Network Maximum Out-of-Pocket (Single/Family)	$5,250/$10,500	$5,000/$10,000	$4,000/$8,000	$4,750/$9,500
In-Network Coinsurance	10%	20%	10%	10%
Outpatient Facility Copayment	Freestanding Facility – $150 after deductible Hospital Facility – $300 after deductible	Freestanding Facility – $150 after deductible Hospital Facility – $250 after deductible	10% after deductible	Freestanding Facility – $150 after deductible Hospital Facility – $250 after deductible
Inpatient Facility Copayment	10% after deductible	20% after deductible	10% after deductible	Deductible then $250 per day to $2,500 maximum per year
Emergency Room	$500	$400	10% after deductible	$500
Prescription Drug Coverage	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100	Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***	Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Gold Plans (Continued)

Option	❑ NY G LBTY GT 30/60/1000/100 EPO 19*	❑ NY G FRDM NG 25/40/1000/80 PPO 19	❑ NY G FRDM NG 1500/90 PPO HSA 19
Network	Liberty	Freedom	Freedom
Copayment: **a. PCP** **b. Specialist**	 $30 per visit $60 per visit	 $25 per visit $40 per visit	 10% after deductible 10% after deductible
In-Network Deductible (Single/Family)	$1,000/$2,000	$1,000/$2,000	$1,500/$3,000
In-Network Maximum Out-of-Pocket (Single/Family)	$4,500/$9,000	$5,000/$10,000	$4,000/$8,000
In-Network Coinsurance	N/A	20%	10%
Outpatient Facility Copayment	Freestanding Facility – $150 after deductible Hospital Facility – $250 after deductible	Freestanding Facility – $150 after deductible Hospital Facility – $250 after deductible	10% after deductible
Inpatient Facility Copayment	Deductible then $500 per day to $2,000 maximum per admission	20% after deductible	10% after deductible
Emergency Room	$500	$500	10% after deductible
Out-of-Network Deductible (Single/Family)	N/A	$3,000/$6,000	$3,000/$6,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	$7,500/$15,000	$7,500/$15,000
Out-of-Network Coinsurance	N/A	40%	40%
Prescription Drug Coverage	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100	Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100	Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Gold Plans (Continued)

Option	❑ NY G LBTY GT 25/45/1500/80 EPO LA 19	❑ NY G FRDM NG 30/60/2000/70 EPO 19	❑ NY G LBTY NG 30/60/2000/70 EPO 19	❑ NY G FRDM NG 30/60/2000/70 PPO 19
Network	Liberty	Freedom	Liberty	Freedom
Access	Gated	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $25 per visit $45 per visit	 $30 per visit $60 per visit	 $30 per visit $60 per visit	 $30 per visit $60 per visit
In-Network Deductible (Single/Family)	$1,500/$3,000	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
In-Network Maximum Out-of-Pocket (Single/Family)	$6,000/$12,000	$7,900/$15,800	$7,900/$15,800	$7,900/$15,800
In-Network Coinsurance	20%	30%	30%	30%
Outpatient Facility Copayment	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Inpatient Facility Copayment	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Emergency Room	20% after deductible	$500	$500	$500
Out-of-Network Deductible (Single/Family)	N/A	N/A	N/A	$4,000/$8,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	N/A	N/A	$10,000/$20,000
Out-of-Network Coinsurance	N/A	N/A	N/A	50%
Prescription Drug Coverage	Tier 1 – $5 copayment Tier 2 – $45 copayment Tier 3 – $75 copayment $150 rx deductible** Mail-Order - 2.5x copay	Tier 1 – $15 copayment Tier 2 – $45 copayment Tier 3 – $75 copayment $100 rx deductible** Mail-Order - 2.5x copay	Tier 1 – $15 copayment Tier 2 – $45 copayment Tier 3 – $75 copayment $100 rx deductible** Mail-Order - 2.5x copay	Tier 1 – $15 copayment Tier 2 – $45 copayment Tier 3 – $75 copayment $100 rx deductible** Mail-Order - 2.5x copay

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

*Referrals are required for this plan design.

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

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

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	❑ NY S LBTY NG 30/75/3000/60 EPO 19	❑ NY S LBTY NG 25/50/2000/80 EPO HSA 19	❑ NY S FRDM NG 2000/70 EPO HSA 19	❑ NY S LBTY GT 25/50/3500/50 EPO 19*
Network	Liberty	Liberty	Freedom	Liberty
Copayment: **a. PCP** **b. Specialist**	$30 per visit $75 per visit	$25 per visit after deductible $50 per visit after deductible	30% after deductible 30% after deductible	$25 per visit $50 per visit
In-Network Deductible (Single/Family)	$3,000/$6,000	$2,000/$4,000	$2,000/$4,000	$3,500/$7,000
In-Network Maximum Out-of-Pocket (Single/Family)	$7,900/$15,800	$5,500/$11,000	$6,550/$13,100	$7,900/$15,800
In-Network Coinsurance	40%	20%	30%	50%
Outpatient Facility Copayment	40% after deductible	Freestanding Facility – $150 after deductible Hospital Facility – $250 after deductible	30% after deductible	50% after deductible
Inpatient Facility Copayment	40% after deductible	20% after deductible	30% after deductible	50% after deductible
Emergency Room	$550 after deductible	$500 after deductible	30% after deductible	50% after deductible
Prescription Drug Coverage	Tier 1 – $15 copayment Tier 2 – $65 copayment Tier 3 – 50% copayment to $800 maximum Mail-Order – 2.5x copay Deductible** – $100	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***	Tier 1 – $15 copayment Tier 2 – $65 copayment Tier 3 – $85 copayment Mail-Order – 2.5x copay Deductible** – $100

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Silver Plans (Continued)

Option	❑ NY S FRDM NG 25/50/2000/80 EPO HSA 19	❑ NY S LBTY NG 10/60/2000/70 EPO PA 19	❑ NY S FRDM NG 40/70/2500/70 EPO 19	❑ NY S LBTY NG 40/70/2500/70 EPO 19
Network	Freedom	Liberty	Freedom	Liberty
Copayment: **a. PCP** **b. Specialist**	 $25 per visit after deductible $50 per visit after deductible	 $10 per visit $60 per visit after deductible	 $40 per visit $70 per visit	 $40 per visit $70 per visit
In-Network Deductible (Single/Family)	$2,000/$4,000	$2,000/$4,000	$2,500/$5,000	$2,500/$5,000
In-Network Maximum Out-of-Pocket (Single/Family)	$5,500/$11,000	$7,900/$15,800	$7,900/$15,800	$7,900/$15,800
In-Network Coinsurance	20%	30%	30%	30%
Outpatient Facility Copayment	Freestanding Facility – $150 after deductible Hospital Facility – $250 after deductible	Freestanding Facility – $150 after deductible Hospital Facility – $300 after deductible	30% after deductible	30% after deductible
Inpatient Facility Copayment	20% after deductible	$250 copay per day to $1,250 max after deductible	30% after deductible	30% after deductible
Emergency Room	$500 after deductible	50% after deductible	30% after deductible	30% after deductible
Prescription Drug Coverage	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible* * *	Tier 1 – $5 copayment Tier 2 – $65 copayment Tier 3 – $90 copayment Mail-Order – 2.5x copay Deductible* *	Tier 1 – $15 copayment Tier 2 – $45 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible - $200 * *	Tier 1 – $15 copayment Tier 2 – $45 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible - $200 * *

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Silver Plans (Continued)

Option	❑ NY S FRDM NG 30/60/2000/80 PPO HSA 19	❑ NY S FRDM NG 40/70/2500/70 PPO 19	❑ NY S LBTY GT 30/70/4000/60 EPO LA 19*	❑ NY S LBTY GT 20/75/4000/70 EPO PA 19*
Network	Freedom	Freedom	Liberty	Liberty
Access	N/A	N/A	Gated	Gated
Copayment: **a. PCP** **b. Specialist**	$30 per visit after deductible $60 per visit after deductible	$40 per visit $70 per visit	$30 per visit $70 per visit	$20 per visit $75 per visit after deductible
In-Network Deductible (Single/Family)	$2,000/$4,000	$2,500/$5,000	$4,000/$8,000	$4,000/$8,000
In-Network Maximum Out-of-Pocket (Single/Family)	$5,500/$11,000	$7,900/$15,800	$7,350/$14,700	$7,900/$15,800
In-Network Coinsurance	20%	30%	40%	30%
Outpatient Facility Copayment	Freestanding Facility – $150 after deductible Hospital Facility – $250 after deductible	30% after deductible	40% after deductible	Freestanding Facility – $300 after deductible Hospital Facility – $600 after deductible
Inpatient Facility Copayment	20% after deductible	30% after deductible	40% after deductible	Deductible then $500 per day to a maximum of $2000
Emergency Room	20% after deductible	30% after deductible	40% after deductible	50% after deductible
Out-of-Network Deductible (Single/Family)	$4,000/$8,000	$4,000/$8,000	N/A	N/A
Out-of-Network Maximum Out-of-Pocket (Single/Family)	$10,000/$20,000	$10,000/$20,000	N/A	N/A
Out-of-Network Coinsurance	50%	50%	N/A	N/A
Prescription Drug Coverage	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***	Tier 1 – $15 copayment Tier 2 – $45 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible - $200**	Tier 1 – $15 copayment Tier 2 – $50 copayment Tier 3 – $90 copayment Mail-Order - 2.5x copay Deductible $150**	Tier 1 – $10 copayment Tier 2 – $65 copayment Tier 3 – $90 copayment Mail-Order - 2.5x copay Deductible**

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

*Referrals are required for this plan design.

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

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

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	❑ NY B FRDM NG 5500/70 EPO HSA 19	❑ NY B LBTY NG 5500/70 EPO HSA 19	❑ NY B LBTY NG 30/60/6000/80 PPO HSA 19	❑ NY B LBTY NG 6550/100 EPO HSA 19
Network	Freedom	Liberty	Liberty	Liberty
Copayment: **a. PCP** **b. Specialist**	30% after deductible 30% after deductible	30% after deductible 30% after deductible	$30 per visit after deductible $60 per visit after deductible	100% after deductible 100% after deductible
In-Network Deductible (Single/Family)	$5,500/$11,000	$5,500/$11,000	$6,000/$12,000	$6,550/$13,100
In-Network Maximum Out-of-Pocket (Single/Family)	$6,700/$13,400	$6,700/$13,400	$6,550/$13,100	$6,550/$13,100
In-Network Coinsurance	30%	30%	20%	N/A
Outpatient Facility Copayment	30% after deductible	30% after deductible	20% after deductible	100% after deductible
Inpatient Facility Copayment	30% after deductible	30% after deductible	20% after deductible	100% after deductible
Emergency Room	50% after deductible	50% after deductible	20% after deductible	100% after deductible
Out-of-Network Deductible (Single/Family)	N/A	N/A	$10,000/$20,000	N/A
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	N/A	$25,000/$50,000	N/A
Out-of-Network Coinsurance	N/A	N/A	20%	N/A
Out-of-Network Reimbursement	N/A	N/A	140% MNRP	N/A
Prescription Drug Coverage	Tier 1 – $10 copayment Tier 2 – $40 copayment Tier 3 – $80 copayment Mail-Order – 2.5x copay Deductible* * *	Tier 1 – $10 copayment Tier 2 – $40 copayment Tier 3 – $80 copayment Mail-Order – 2.5x copay Deductible* * *	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible* * *	100% after deductible Mail-Order – 2.5x copay Deductible* * *

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

D. Bronze Plans (continued)

Option	❑ **NY B LBTY NG 25/75/3300/70 EPO HSA 19**
Network	Liberty
Access	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $25 per visit after deductible $75 per visit after deductible
In-Network Deductible (Single/Family)	$3,300/$6,600
In-Network Maximum Out-of-Pocket (Single/Family)	$6,700/$13,400
In-Network Coinsurance	30%
Outpatient Facility Copayment	30% after deductible
Inpatient Facility Copayment	30% after deductible
Emergency Room	30% after deductible
Out-of-Network Deductible (Single/Family)	N/A
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A
Out-of-Network Coinsurance	N/A
Prescription Drug Coverage	30% after deductible * * *

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year ❑ contract year basis.
* *Deductible applies to Tier 2 and Tier 3 drugs.
* * *NOTE: All In-Network medical and pharmacy services are subject to the In-Network deductible. Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copayment will apply based on the option selected at plan inception. Out-of network benefits are accumulated separately. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket has been met.

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	❑ NY P MTRO GT 15/30/100 EPO 19[1]	❑ NY G MTRO NG 25/40/1250/80 EPO 19	❑ NY G MTRO GT 25/40/1250/80 EPO 19[1]
Network	Metro	Metro	Metro
Copayment: **a. PCP** **b. Specialist**	 $15 per visit $30 per visit	 $25 per visit $40 per visit	 $25 per visit $40 per visit
In-Network Deductible (Single/ Family)	N/A	$1,250/$2,500	$1,250/$2,500
In-Network Maximum Out-of-Pocket (Single/Family)	$2,500/$5,000	$5,000/$10,000	$5,500/$11,000
In-Network Coinsurance	N/A	20%	20%
Outpatient Facility Copayment	Freestanding Facility –$100 Hospital Facility – $500	Freestanding Facility – $200 after deductible Hospital Facility – $500 after deductible	Freestanding Facility – $200 after deductible Hospital Facility – $500 after deductible
Inpatient Facility Copayment	$200 per day to $800 maximum per admission	20% after deductible	20% after deductible
Emergency Room	$200	$400	$500
Prescription Drug Coverage	Tier 1 – $10 copayment Tier 2 – $65 after deductible Tier 3 – $90 after deductible Mail-Order – 2.5x copay Deductible - $100	Tier 1 – $10 copayment Tier 2 – $65 after deductible Tier 3 – $90 after deductible Mail-Order – 2.5x copay Deductible - $100	Tier 1 – $10 copayment Tier 2 – $65 after deductible Tier 3 – $90 after deductible Mail-Order – 2.5x copay Deductible – $100

E. Metro Plans (Continued)

Option	❑ NY S MTRO GT 15/70/3000/70 EPO PA 19[1]	❑ NY S MTRO NG 30/80/3000/70 EPO ME 19	❑ NY S MTRO GT 35/50/1500/70 EPO HSA 19[1, 3]	❑ NY S MTRO GT 30/80/3000/70 EPO 19[1]
Network	Metro	Metro	Metro	Metro
Copayment: **a. PCP** **b. Specialist**	$15 per visit $70 per visit after deductible	$30 per visit $80 per visit	$35 per visit after deductible $50 per visit after deductible	$30 per visit $80 per visit
In-Network Deductible (Single/Family)	$3,000/$6,000	$3,000/$6,000	$1,500/$3,000	$3,000/$6,000
In-Network Maximum Out-of-Pocket (Single/Family)	$7,900/$15,800	$7,900/$15,800	$6,550/$13,100	$7,900/$15,800
In-Network Coinsurance	30%	30%	30%	30%
Outpatient Facility Copayment	Freestanding Facility – $250 after deductible Hospital Facility – $500 after deductible	30% after deductible	Freestanding Facility – $300 after deductible Hospital Facility – $750 after deductible	Freestanding Facility – 30% after deductible Hospital Facility – 30% after deductible
Inpatient Facility Copayment	$400 copay per day/$1,600 maximum after deductible	30% after deductible	30% after deductible	30% after deductible
Emergency Room	50% after deductible	30% after deductible	$500 after deductible	30% after deductible
Prescription Drug Coverage	Tier 1 – $5 copayment Tier 2 – $65 after deductible Tier 3 – $90 after deductible Mail-Order – 2.5x copay Deductible[2]	Tier 1 – $10 copayment Tier 2 – $65 copayment after deductible Tier 3 – $90 copayment after deductible Mail-Order – 2.5x copay Deductible – $100	Tier 1 – $10 copayment Tier 2 – $65 copayment Tier 3 – 50% copayment to $800 maximum Mail-Order – 2.5x copay Deductible[3]	Tier 1 – $10 copayment Tier 2 – $65 after deductible Tier 3 – $90 after deductible Mail-Order – 2.5x copay Deductible – $100

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

E. Metro Plans (Continued)

Option	❑ NY B MTRO GT 5500/70 EPO HSA 19[1, 3]	❑ NY B MTRO GT 40/75/5750/50 EPO HSA 19[1, 3]	❑ NY B MTRO GT 6550/100 EPO HSA 19[1, 3]
Network	Metro	Metro	Metro
Copayment: **a. PCP** **b. Specialist**	30% after deductible 30% after deductible	$40 per visit after deductible $75 per visit after deductible	100% after deductible 100% after deductible
In-Network Deductible (Single/ Family)	$5,500/$11,000	$5,750/$11,500	$6,550/$13,100
In-Network Maximum Out-of-Pocket (Single/Family)	$6,700/$13,400	$6,700/$13,400	$6,700/$13,400
In-Network Coinsurance	30%	50%	N/A
Outpatient Facility Copayment	30% after deductible	Freestanding Facility – $500 after deductible Hospital Facility – $1000 after deductible	100% after deductible
Inpatient Facility Copayment	30% after deductible	50% after deductible	100% after deductible
Emergency Room	30% after deductible	$500 after deductible	100% after deductible
Prescription Drug Coverage	Tier 1 – $10 copayment Tier 2 – $65 copayment Tier 3 – $90 copayment Mail-Order – 2.5x copay Deductible[3]	Tier 1 – $10 copayment Tier 2 – $65 copayment Tier 3 – $90 copayment Mail-Order – 2.5x copay Deductible[3]	100% after deductible Mail-Order – 2.5x copay Deductible[3]

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

[1] Referrals are required for this plan design.

Once the In-Network deductible has been satisfied by an individual, the applicable medical coinsurance will apply based on the selected plan. If the individual is enrolled as a couple, Parent/children or family and the family deductible is met, then no further deductible is required, and the applicable medical coinsurance will apply based on the selected plan.

[2] Referrals are required for this plan design. Deductible applies to Tier 2 and Tier 3 drugs.

NOTE: Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copayment will apply based on the selected plan. If the individual is enrolled as a couple, Parent/children or family and the family deductible is met, then no further deductible is required, and the applicable medical coinsurance and prescription drug copayment will apply based on the selected plan.

[3] Referrals are required for this plan design.

NOTE: All In-Network medical and pharmacy services are subject to the In-Network deductible.

Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copayment will apply based on the option selected at plan inception. No individual enrolled as a couple, Parent/children or family may satisfy the deductible until the entire family deductible has been met. Each individual on a enrolled as a couple, Parent/children or family must satisfy the individual out-of-pocket maximum, until the entire family out-of-pocket maximum has been met.

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. 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. 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.

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:_____

X

Signature of Authorized Company Representative | Title

Witness | Duly Licensed Resident Agent/Broker