OXFORD HEALTH PLANS®

A UnitedHealthcare Company

Freedom Plan® Metro℠
Liberty Plan Metro℠
Freedom Plan® Metro℠ Access
Liberty Plan Metro℠ Access
Oxford Exclusive Plan℠ Metro
Freedom Plan® Direct℠
Liberty Plan Direct℠
Oxford MyPlan℠
Oxford HSA Exclusive℠
Oxford HSA Direct℠

NY Small Group Application - OHI

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

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, Zipcode

d. Phone Number Ext.

e. Fax Number

f. E-mail 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, Zipcode

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.

1. **Effective date:** We request that this coverage be effective: _____.
   (Month / Day 1st or 15th / Year)
2. **Anniversary date:** If the initial effective date is the 15th of the month, then the anniversary date is the first of the month following the effective date month.
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. **Total Number of Employees:** _____
5. **Employee Eligibility:** All full-time, permanent employees who work at least _____ hours per week (minimum 20 hours/week) are eligible.
6. **Number of Active Eligible Employees:** _____
7. **Number of Employees** enrolling with Oxford Health Plans with the new group application _____
8. **Number of Waivers** for health coverage submitted _____
9. **Continuation of Coverage:** Are you enrolling any former employees under COBRA or State Continuation Provisions? ❑ Yes ❑ No
   If yes, how many? _____
10. **Other group health or HMO coverage:** Indicate below other group health coverage which is still in force or which terminated within the past three years.

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

Eligibility & 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

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

iii) Waiting Period for Rehires

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

If yes, waived if rehired within _____ months.

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

iii) Waiting Period for Rehires

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

If yes, waived if rehired within _____ months.

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

iii) Waiting Period for Rehires

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

If yes, waived if rehired within _____ months.

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

iii) Waiting Period for Rehires

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

If yes, waived if rehired within _____ months.

III. PRODUCT AND PLAN DESIGNS

A. Oxford Plan Metro

Referrals are required for these plan designs.

Instructions: Please select a plan option and check off any variable items as provided below.

	Freedom Network				Liberty Network	
Options	❑ **Plan 1**	❑ **Plan 2**	❑ **Plan 3**	❑ **Plan 4**	❑ **Plan 5**	❑ **Plan 6**
Copayment:						
a. PCP	$15 per visit	$25 per visit	$15 per visit	$25 per visit	$15 per visit	$25 per visit
b. Specialist	$25 per visit	$40 per visit	$25 per visit	$40 per visit	$25 per visit	$40 per visit
Out-of-Network Deductible	$1,000 Single $3,000 Family	$1,000 Single $3,000 Family	$2,000 Single $6,000 Family	$2,000 Single $6,000 Family	$2,000 Single $6,000 Family	$2,000 Single $6,000 Family
Out-of-Network Reimbursement	❑150% of Medicare rate ❑70% UCR	❑150% of Medicare rate ❑70% UCR	❑150% of Medicare rate ❑70% UCR	❑150% of Medicare rate ❑70% UCR	❑150% of Medicare rate ❑70% UCR	❑150% of Medicare rate ❑70% UCR
Inpatient/Outpatient Facility Copayment	$100 per continuous confinement (Inpatient/ Outpatient)	$250 per day up to five days Inpatient ($1,250 max. copayment per year) / $250 Outpatient	$500 Inpatient/ $150 Outpatient	$350 per day up to five days Inpatient ($1,750 max. copayment per year) / $250 Outpatient	$100 per continuous confinement (Inpatient/ Outpatient)	$250 per day up to five days Inpatient ($1,250 maximum copayment per year) /$250 Outpatient

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

All plans contain: 70% Out-of-Network Coinsurance $10,000 Out-of-Network Coinsurance limit $75 Emergency Room Copayment

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium ❑ Other:_____
SUBJECT TO HOME OFFICE APPROVAL

❑ Age 25 Dependent Student Cutoff (Age 23 is standard)

Note: Cutoff must match for all plan designs selected.

Please select optional prescription drug coverage:

Options	Generic	Preferred Brand	Non-Preferred Brand	Mail-Order	Deductible ** (Please select one)
❑ Option 1	$10 copayment	$25 copayment	$50 copayment	2x copayment	❑$50 ❑$100 ❑$250 ❑$500
❑ Option 2	$15 copayment	50%	50%	2x copayment or 50%	❑$50 ❑$100 ❑$250 ❑$500
❑ Option 3*	$15 copayment	$30 copayment	$60 copayment	$30/$60/$180	$100 (Required)
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

* This pharmacy plan has a maximum per contract year of $3,000, applicable to all drugs.

** Deductible waived for generic drugs.

Contraceptives:

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

B. Freedom Plan Metro Access and Liberty Plan Metro Access (Non-gated - No referrals required)

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

Please Select Network: ❑ Freedom® ❑ Libertysm

Options	❑ Metro Plan Access Option 1	❑ Metro Plan Access Option 2
Office visit copayment:	$20 PCP/$30 specialist	$30 PCP/$50 specialist
Hospital copayment	$500 per admission	$500 per admission
Outpatient/Hospital Ambulatory surgery	$250 copayment	$500 copayment
Out-of-Network deductible - Single/Family	$2,000/$6,000	$3,000/$9,000
Out-of-Network coinsurance - Single/Family	70% to $10,000/$30,000	70% to $10,000/$30,000
Out-of-Network reimbursement	❑ 150% of Medicare rate ❑ 70% UCR	❑ 150% of Medicare rate ❑ 70% UCR

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

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium ❑ Other:_____
SUBJECT TO HOME OFFICE APPROVAL

❑ Age 25 Dependent Student Cutoff (Age 23 is standard)

Note: Cutoff must match for all plan designs selected.

Please select optional prescription drug coverage:

Options	Generic	Preferred Brand	Non-Preferred Brand	Mail-Order	Deductible ** (Please select one)
❑ Option 1	$10 copayment	$25 copayment	$50 copayment	2x copayment	❑$50 ❑$100 ❑$250 ❑$500
❑ Option 2	$15 copayment	50%	50%	2x copayment or 50%	❑$50 ❑$100 ❑$250 ❑$500
❑ Option 3*	$15 copayment	$30 copayment	$60 copayment	$30/$60/$180	$100 (Required)
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

* This pharmacy plan has a maximum per contract year of $3,000, applicable to all drugs.

** Deductible waived for generic drugs.

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

C. Oxford Exclusive Plan℠ Metro (Non-gated - No referrals required)

Instructions: Please select a plan option and check off any variable items as provided below.

Please Select Network: ❑ Freedom® ❑ Liberty℠

Options	❑ Plan 1	❑ Plan 2
Copayment:		
a. PCP	$15 per visit	$25 per visit
b. Specialist	$30 per visit	$50 per visit
Outpatient Facility Copayment	$150 per incident	$300 per incident
Inpatient Facility Copayment	$150 per continuous confinement	$300 per day to five day maximum
Emergency Room	$75	$75

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium ❑ Other:_____
SUBJECT TO HOME OFFICE APPROVAL

❑ Age 25 Dependent Student Cutoff (Age 23 is standard)

Note: Cutoff must match for all plan designs selected

Please select optional prescription drug coverage:

Options	Generic	Preferred Brand	Non-Preferred Brand	Mail-Order	Deductible** (Please select one)
❑ Option 1	$10 copayment	$25 copayment	$50 copayment	2x copayment	❑$50 ❑$100
❑ Option 2	$15 copayment	50%	50%	2x copayment or 50%	❑$50 ❑$100
❑ Option 3*	$15 copayment	$30 copayment	$60 copayment	$30/$60/$180	$100 (Required)
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

* This pharmacy plan has a maximum per contract year of $3,000, applicable to all drugs.
** Deductible waived for generic drugs.

Contraceptives:

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

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III. PRODUCT AND PLAN DESIGNS (CONTINUED)

D. Freedom Plan® Direct℠ and Liberty Plan Direct℠

No referrals are required for these plan designs.

In-Network/Out-of-Network

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6
Copayment	$15 PCP $25 Specialist	$25 PCP $40 Specialist	$25 PCP $40 Specialist	N/A	N/A	N/A
Single Deductible	$500/$1,000	$500/$1,000	$1,000/$2,000	$500/$1,000	$2,000/$2,000	$1,000/$2,000
Family Deductible	$1,000/$2,000	$1,000/$2,000	$2,000/$4,000	$1,000/$2,000	$4,000/$4,000	$2,000/$4,000
Coinsurance	90%/70%	80%/60%	80%/60%	90%/70%	90%/70%	80%/60%
Out-of-Network	❑ 150% of Medicare rate ❑ 70% UCR	❑ 150% of Medicare rate ❑ 70% UCR	❑ 150% of Medicare rate ❑ 70% UCR	❑ 150% of Medicare rate ❑ 70% UCR	❑ 150% of Medicare rate ❑ 70% UCR	❑ 150% of Medicare rate ❑ 70% UCR
Single Maximum Out-of-Pocket	$1,500/$4,000	$2,500/$5,000	$3,000/$6,000	$1,500/$4,000	$3,000/$5,000	$3,000/$6,000
Family Maximum Out-of-Pocket	$3,000/$8,000	$5,000/$10,000	$6,000/$12,000	$3,000/$8,000	$6,000/$10,000	$6,000/$12,000

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

Please Select Network: ❑ Freedom® ❑ Liberty℠

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium ❑ Other:_____
SUBJECT TO HOME OFFICE APPROVAL

❑ Age 25 Dependent Student Cutoff (Age 23 is standard)

Note: Cutoff must match for all plan designs selected.

Please select optional prescription drug coverage:

Options	Generic	Preferred Brand	Non-Preferred Brand	Mail-Order	Deductible ** (Please select one)
❑ Option 1	$10 copayment	$25 copayment	$50 copayment	2x copayment	❑ $50 ❑ $100 ❑ $150 ❑ $250
❑ Option 2	$15 copayment	50%	50%	2x copayment or 50%	❑ $50 ❑ $100 ❑ $150 ❑ $250
❑ Option 3*	$15 copayment	$30 copayment	$60 copayment	$30/$60/$180	$100 (Required)
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

* This pharmacy plan has a maximum per contract year of $3,000, applicable to all drugs.
** Deductible waived for generic drugs.

Contraceptives:

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

E. Oxford MyPlan℠

Please note: Groups enrolling in the Oxford MyPlan℠ Health Reserve Account Group Application Form (#6740).

Please Select Network: ❑ **Freedom®** ❑ **Liberty℠**

No referrals are required for these plan designs.

In-Network/Out-of-Network

Please select a plan type:

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3
Copayment	$25 PCP $40 Specialist	N/A	N/A
Single Deductible	$1,000/$2,000	$1,000/$2,000	$2,000/$2,000
Family Deductible	$2,000/$4,000	$2,000/$4,000	$4,000/$4,000
Coinsurance	80%/60%	80%/60%	90%/70%
Out-of-Network Reimbursement	❑ 150% of Medicare rate ❑ 70% UCR	❑ 150% of Medicare rate ❑ 70% UCR	❑ 150% of Medicare rate ❑ 70% UCR
Single Maximum Out-of-Pocket	$3,000/$6,000	$3,000/$6,000	$3,000/$5,000
Family Maximum Out-of-Pocket	$6,000/$12,000	$6,000/$12,000	$6,000/$10,000

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

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium

❑ Age 25 Dependent Student Cutoff (Age 23 is standard)
Note: Cutoff must match for all plan designs selected.

Please select optional prescription drug coverage:

Options	Generic	Preferred Brand	Non-Preferred Brand	Mail-Order	Deductible ** (Please select one)
❑ Option 1	$10 copayment	$25 copayment	$50 copayment	2x copayment	$50 (Required)
❑ Option 2	$15 copayment	50%	50%	2x copayment or 50%	$50 (Required)
❑ Option 3*	$15 copayment	$30 copayment	$60 copayment	$30/$60/$180	$100 (Required)
❑ Waived Coverage	N/A	N/A	N/A	N/A	N/A

*This pharmacy plan has a maximum per contract year of $3,000, applicable to all drugs.

** Deductible waived for generic drugs.

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

F. Oxford HSA Exclusive℠

Please note: **Groups enrolling in the Oxford HSA Exclusive must also fill out an Oxford HSA Bank Notification Form (#7423).**

Please Select Network: ❑ Freedom® ❑ Libertysm

No referrals are required for these plan designs.

In-Network Only

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3
Single Deductible **	$1,100	$2,000	$2,850
Family Deductible **	$2,200	$4,000	$5,700
Coinsurance	100%	100%	100%
Single Medical Maximum Out-of-Pocket	$1,100	$2,000	$2,850
Family Medical Maximum Out-of-Pocket	$2,200	$4,000	$5,700

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

Please select prescription drug coverage: **(Required)

Options	Generic	Preferred Brand	Non-Preferred Brand	Mail-Order
❑ Option 1	$10 copayment	$25 copayment	$50 copayment	2x copayment
❑ Option 2	$15 copayment	50%	50%	2x copayment or 50%

Contraceptives:

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

****NOTE:** As of April 1, 2005, all in-network medical and pharmacy services are subject to the in-nework deductible. Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copay will apply based on the option selected at plan inception.
Out-of-network benefits are accumulated separately.

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium ❑ Other:_____

SUBJECT TO HOME OFFICE APPROVAL

❑ Age 25 Dependent Student Cutoff (Age 23 is standard)

Note: Cutoff must match for all plan designs selected

G. Oxford HSA Direct℠

Please note: **Groups enrolling in the Oxford HSA Direct must also fill out an Oxford HSA Bank Notification Form (#7423).**

Please Select Network: ❑ Freedom® ❑ Liberty℠

No referrals are required for these plan designs.

In-Network/Out-of-Network

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6
Single Deductible **	$1,100/ $2,000	$2,000/ $2,000	$2,850/ $2,850	$1,100/ $2,000	$2,000/ $2,000	$2,850/ $2,850
Family Deductible **	$2,200/ $4,000	$4,000/ $4,000	$5,700/ $5,700	$2,200/ $4,000	$4,000/ $4,000	$5,700/ $5,700
Coinsurance	80%/60%	90%/70%	90%/70%	100%/70%	100%/70%	100%/70%
Single Medical Maximum Out-of-Pocket	$3,100/ $6,000	$3,000/ $5,000	$3,850/ $5,850	$1,100/ $5,000	$2,000/ $5,000	$2,850/ $5,850
Family Medical Maximum Out-of-Pocket	$6,200/ $12,000	$6,000/ $10,000	$7,700/ $11,700	$2,200/ $10,000	$4,000/ $10,000	$5,700/ $11,700

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

Additional Benefit Options: ❑ Vision ❑ Dental Enhanced ❑ Dental Premium ❑ Other:_____

SUBJECT TO HOME OFFICE APPROVAL

❑ Age 25 Dependent Student Cutoff (Age 23 is standard)

Note: Cutoff must match for all plan designs selected.

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

Options	Generic	Preferred Brand	Non-Preferred Brand	Mail-Order
❑ Option 1	$10 copayment	$25 copayment	$50 copayment	2x copayment
❑ Option 2	$15 copayment	50%	50%	2x copayment or 50%

Contraceptives:

❒ Yes (Standard)

❒ No (Qualified State Exempt Groups Only)

****NOTE:** As of April 1, 2005, all in-network medical and pharmacy services are subject to the in-nework deductible. Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copay will apply based on the option selected at plan inception.
Out-of-network benefits are accumulated separately.

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 Broker/Agent :			
2. Oxford Broker Code (*Required*):			
3. Social Security # or Federal Tax ID #:			
4. Broker Street Address:			
5. City, State, Zipcode:			
6. Telephone Number:			
7. Fax Number:			
8. E-mail Address:			
9. Commission Split %:			
10. Oxford Sales Representative:			
Comments:			

VI. CONSENT

AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford Health Plans 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 Health Plan 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 Oxford 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. 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 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. Further, I hereby certify on behalf of the Applicant that the Applicant has not had a group health policy terminated within the past 12 months due to failure to pay premiums.

Dated at:_____this_____day of_____20_____.

_____

Full legal name of firm:_____

The above named company confirms that we employ no more than 50 full-time, non-union employees.

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.

Oxford Health Insurance, Inc.

X_____

Signature of Authorized Officer of the Company | Title

_____

Witness | Duly Licensed Resident Agent/Broker