

NY Small Group Application - OHI

Oxford Health Insurance Inc. • www.oxfordhealth.com

Mailing Address: Group Enrollment Department, 14 Central Park Drive, Hooksett, NH 03106

Freedom Plan® MetrosM Liberty PlansM Metro Freedom Plan® MetrosM Access Liberty PlansM Metro Access Oxford Exclusive PlansM Metro Oxford EaseSM Freedom Plan® Directsm
Liberty Plansm Direct
Oxford MyPlansm
Oxford® HSA Exclusivesm
Oxford® HSA Directsm

IVIAI	ning Address: Group Enrollment Departmen)														
	I. GENERAL I	N F	0 1	K M	A T	10	N															
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)																	<u> </u>			<u> </u>	
	City, State, Zip code																					
	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	g stater	nents:																			
	a. Name																					
	b. Title																					
	c. Address																					
	(If different from primary) City, State, Zip code																					
]				- 	,				7	_							
	d. Phone Number														Ext							
	e. Fax Number																					
5.	Full legal name of each subsidiary and/or	r affiliat	ted com	npany v	/hose e	mploye	es are	to be o	overed	(if app	licable)	:										
6.	Nature of Business:																					
]										J [
7.	SIC Code:]]]]]]	1]	7											
8.	Tax Identification Number:																					

II. ADMINISTRATIVE INFORMATION

The	term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate of Cov	-		
1.	Effective date: We request that this coverage be effective:		at the	
2.	Anniversary date: If the initial effective date is the 15 th of the month, then the anniversary date is the	first of the	(Month / Day 1 st or 15 th / Year) month following the effective date month.	
3.	Open enrollment period: The open enrollment period is the month prior to your anniversary date. The following the period.	open enro	lment effective date is the first of the month	
4.	Total Number of Employees:			
5.	Employee Eligibility: All full-time, permanent employees who work at least hour.	s per wee	k (minimum 20 hours/week) are eligible.	
6.	Number of Current Eligible Employees:			
7.	Number of Employees enrolling with Oxford with the new group application:			
8.	Number of Walvers for health coverage submitted:			
9.	Continuation of Coverage: Are you enrolling any former employees under COBRA or State Continual If yes, how many?	tion Provisi	ons? 🗀 Yes 🗀 No	
10.	Other group health or HMO coverage: Indicate below other group health coverage which is still in fi	orce or wh	ich terminated within the past three years.	
	Type of coverage Name of carrier		Effective date	If terminated, date terminated
_				
	Integration with Medicare Benefits: Health Benefits covered by Medicare Part A and B are carvee coverage.	ved out for	Retired Employees age 65 or over and their d	ependents age 65 or over if the group offers
	CLASS I		CLAS	S II
Defi	nition of Class I	Detir	ition of Class II	
i)	Eligibility/Termination	i)	Eligibility/Termination	
	Date on which the employee completesdays/months (circle one) of continuous service.		Date on which the employee completes of continuous service.	days/months (circle one
	Termination will be the date of termination of employment.		Termination will be the date of termination of	f employment.
ii)	Eligibility/Termination	ii)	Eligibility/Termination	
	On the first day of the calendar month coinciding with or next following the date on which the employee completesdays/months (circle one) of continuous service.		On the first day of the calendar month or following the date on which the employer (circle one) of continuous service.	
	Termination will be on the last day of the calendar month.		Termination will be on the last day of the cale	endar month.
iii)	Waiting Period for Rehires	iii)	Waiting Period for Rehires	
	Waiting Period Waived for Rehires?		Waiting Period Waived for Rehires?	Yes 🗖 No
	If yes, waived if rehired within months.	1	If yes, waived if rehired within mo	onths.

II. ADMINISTRATIVE INFORMATION (CONTINUED)

CLASS III Definition of Class III Eligibility/Termination ☐ Date on which the employee completes ______days/months (circle one) of continuous service. Termination will be the date of termination of employment. 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. Waiting Period for Rehires Waiting Period Waived for Rehires? 🗇 Yes 🔲 No If yes, waived if rehired within _____ months. **CLASS V** Definition of Class V _____ Eligibility/Termination i) ☐ Date on which the employee completes _____days/months (circle one) of continuous service. Termination will be the date of termination of employment. 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.

Waiting Period for Rehires

If yes, waived if rehired within _____ months.

CLASS IV

i)	Eligibility/Termination
	Date on which the employee completesdays/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 completesdays/months (circle one) of cotinuous service.
	Termination will be on the last day of the calendar month.
iii)	Waiting Period for Rehires
	Waiting Period Waived for Rehires?
	If yes, walved if rehired within months.
Defii	CLASS VI
Defii	nition of Class VI
_	nition of Class VI Eligibility/Termination
_	nition of Class VI
Defii i)	Eligibility/Termination Date on which the employee completesdays/months (circle
_	Eligibility/Termination Date on which the employee completesdays/months (circle one) of continuous service.
i)	Eligibility/Termination Date on which the employee completesdays/months (circle one) of continuous service. Termination will be the date of termination of employment.
i)	Eligibility/Termination Date on which the employee completesdays/months (circle one) of continuous service. Termination will be the date of termination of employment. Eligibility/Termination On the first day of the calendar month coinciding with or next following the date on which the employee completesdays/months (circle one) of co
 i)	Eligibility/Termination Date on which the employee completesdays/months (circle one) of continuous service. Termination will be the date of termination of employment. Eligibility/Termination On the first day of the calendar month coinciding with or next following the date on which the employee completesdays/months (circle one) of continuous service.
i)	Eligibility/Termination Date on which the employee completes

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.

S15 per visit S25 per visit S1,000 Single S3,000 Family 150% of Medicare rate³ Standard¹ UCR S100 per continuous confinement (Inpatient/ Outpatient) nulators are on a calenc ork Coinsurance S10,000 Vis t Cutoff (Age 23 is stan	00 Out-of-Network Coins		S25 per visit S40 per visit S2,000 Single S6,000 Family 150% of Medicare rate3 Standard1 UCR S350 per day up to five days Inpatient (\$1,750 max. copayment per year) / S250 Outpatient	S15 per visit S25 per visit S2,000 Single S6,000 Family 140% of Medicare rate ² S100 per continuous confinement (Inpatient/ Outpatient)	S25 per visit S40 per visit S2,000 Single S6,000 Family 140% of Medicare rate ² S250 per day up to five days Inpatient (S1,250 maximum copayment per year) / S250 Outpatient
\$25 per visit \$1,000 Single \$3,000 Family \$150% of Medicare rate³ \$\text{Standard}^1\$ UCR \$100 per continuous confinement (Inpatient/ Outpatient) mulators are on a calencork Coinsurance \$10,000	S40 per visit S1,000 Single S3,000 Family 150% of Medicare rate3 Standard1 UCR S250 per day up to five days Inpatient (\$1,250 max. copayment per year) / \$250 Outpatient dar year basis. 00 Out-of-Network Coins	\$25 per visit \$2,000 Single \$6,000 Family \$150\% of Medicare rate3 \$\to\$Standard1 UCR \$500 Inpatient/ \$150 Outpatient	\$40 per visit \$2,000 Single \$6,000 Family 150% of Medicare rate³ Standard¹ UCR \$350 per day up to five days Inpatient (\$1,750 max. copayment per year) / \$250 Outpatient	\$25 per visit \$2,000 Single \$6,000 Family 140% of Medicare rate ² \$100 per continuous confinement (Inpatient/ Outpatient)	S40 per visit S2,000 Single S6,000 Family 140% of Medicare rate ² S250 per day up to five days Inpatient (S1,250 maximum copayment per year) /S250 Outpatient
\$3,000 Family 150% of Medicare rate³ Standard¹ UCR \$100 per continuous confinement (Inpatient/ Outpatient) nulators are on a calencork Coinsurance \$10,000	\$3,000 Family 150% of Medicare rate3 Standard¹ UCR \$250 per day up to five days Inpatient (\$1,250 max. copayment per year) / \$250 Outpatient dar year basis. 00 Out-of-Network Coins	\$6,000 Family 150% of Medicare rate³ Standard¹ UCR \$500 Inpatient/ \$150 Outpatient surance limit \$75 En	\$6,000 Family 150% of Medicare rate³ Standard¹ UCR \$350 per day up to five days Inpatient (\$1,750 max. copayment per year) / \$250 Outpatient	S6,000 Family 140% of Medicare rate ² S100 per continuous confinement (Inpatient/ Outpatient)	\$6,000 Family 140% of Medicare rate ² \$250 per day up to five days Inpatient (\$1,250 maximum copayment per year) /\$250 Outpatient
Medicare rate ³ Standard ¹ UCR \$100 per continuous confinement (Inpatient/ Outpatient) mulators are on a calence ork Coinsurance \$10,000	Medicare rate ³ Standard ¹ UCR \$250 per day up to five days Inpatient (\$1,250 max. copayment per year) / \$250 Outpatient dar year basis. 00 Out-of-Network Coins	Medicare rate ³ Standard ¹ UCR S500 Inpatient/ S150 Outpatient surance limit S75 En	Medicare rate ³ Standard ¹ UCR S350 per day up to five days Inpatient (\$1,750 max. copayment per year) / \$250 Outpatient	Medicare rate ² \$100 per continuous confinement (Inpatient/ Outpatient)	Medicare rate ² \$250 per day up to five days Inpatient (\$1,250 maximum copayment per year) /\$250 Outpatient
continuous confinement (Inpatient/ Outpatient) nulators are on a calent ork Coinsurance \$10,00	up to five days Inpatient (\$1,250 max. copayment per year) / \$250 Outpatient dar year basis. 00 Out-of-Network Coins D	\$150 Outpatient surance limit \$75 En	up to five days Inpatient (\$1,750 max. copayment per year) / \$250 Outpatient nergency Room Copayment	continuous confinement (Inpatient/ Outpatient)	five days Inpatient (\$1,250 maximum copayment per year) /\$250 Outpatient
ork Coinsurance \$10,00 □ Vis	00 Out-of-Network Coins			Other:	
ndent Age Extension to	29	ased Mental Illness and Childre	n with Serious Emotional Dis	sturbances	
Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Plea	ise select one)
10 copayment	\$25 copayment	\$50 copayment	2x copayment	\$50 \$100 \$1	\$250 🗖\$500
15 copayment	50%	50%	2x copayment or 50%	\$50 \$100 \$	\$250 🗖\$500
15 copayment	\$30 copayment	\$60 copayment	\$30/\$60/\$180	\$100 (Requi	red)
N/A	N/A	N/A	N/A	N/A	
er 3 drugs.					
11 11 m en	Tier 1 10 copayment 15 copayment N/A 1 per contract year of a r 3 drugs.	Coverage for Biologically B. Jug coverage: Tier 1 Tier 2 10 copayment S25 copayment 50% 5 copayment N/A N/A N/A Per contract year of \$3,000, applicable to all r 3 drugs. No (Qualified State Exemption)	Coverage for Biologically Based Mental Illness and Childre ug coverage: Tier 1 Tier 2 Tier 3 10 copayment \$50 copayment \$50 copayment \$50% \$50% \$50% \$50% \$50 copayment N/A N/A N/A N/A N/A Per contract year of \$3,000, applicable to all drugs. r 3 drugs. d) No (Qualified State Exempt Groups Only)	□ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disug coverage: Tier 1 Tier 2 Tier 3 Mail-Order 10 copayment \$25 copayment \$50 copayment 2x copayment 15 copayment \$30 copayment \$60 copayment \$30/\$60/\$180 N/A N/A N/A N/A N/A I per contract year of \$3,000, applicable to all drugs. If a drugs. I no (Qualified State Exempt Groups Only)	Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances Tier 1 Tier 2 Tier 3 Mail-Order Deductible** (Plee 10 copayment S25 copayment S25 copayment S20 copayment S25 copayment S20 copayment S20 copayment S20 copayment S20 copayment S20 copayment S20 copayment S30 copayment S30/S60/S180 S100 (Required N/A

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¹ The Standard UCR fee schedule contains the maximum allowable fees and is set using data from Ingenix, Inc., the Centers for Medicare and Medicaid Service (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees.

Physican fees are generally set using 70th percentile data from the Prevailing Healthcare Charges System (PHCS) database maintained by Ingenix. We and Ingenix are related companies through common ownership by UnitedHealth Group. The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees.

² When a Medicare rate is not available, reimbursement is based upon 50% of the provider's billed charge.

When a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.

³ When a Medicare rate is not available, reimbursement is based upon ceratin gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group.

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 ■ Liberty ■ Metro Plan Access Option 1 ■ Metro Plan Access Option 2 Options \$30 PCP/\$50 specialist Office visit Copayment \$20 PCP/\$30 specialist \$500 per admission \$500 per admission Hospital Copayment per continous confinement per continuous confinement 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 rate³ ☐ 150% of Medicare rate³ ☐ Standard¹ UCR ☐ Standard¹ UCR Freedom Out-of-Network Reimbursement -140% of Medicare rate² 140% of Medicare rate² Liberty Deductibles and out-of-pocket accumulators are on a calendar year basis. Additional Benefit Options: ☐ Vision ■ Dental Enhanced ☐ Dental Premium □ Other: ☐ Age 25 Dependent Student Cutoff (Age 23 is standard) SUBJECT TO HOME OFFICE APPROVAL Note: Cutoff must match for all plan designs selected. ☐ Mandated Offering - Dependent Age Extension to 29 ■ Domestic Partner ☐ Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances Please select optional prescription drug coverage: Options Tier 1 Tier 2 Tier 3 Mail-Order Deductible** (Please select one) □\$50 □\$100 □\$250 □\$500 Option 1 \$10 copayment \$25 copayment \$50 copayment 2x copayment 2x copayment or 50% □\$50 □\$100 □\$250 □\$500 Option 2 \$15 copayment 50% 50% 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 applies to Tier 2 and Tier 3 drugs. Yes (Standard) ☐ No (Qualified State Exempt Groups Only) Contraceptives: 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 eliaible retirees? ☐ Yes ☐ No

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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.

Tamily Deductible none none S2,000 S2,000 S4,000 N/A Coinsurance none none 80% to 90% to 90% to 90% to 90% to 910,000/\$20,000 S10,000/\$20,000	a. PCP b. Specialist Single Deductible Family Deductible Coinsurance Dutpatient Facility Copayment Impatient Facility Copayment Confinement Family Deductible Consurance S150 per incident confinement S75 Copayment Confinement Confineme	'	☐ Plan 2	Plan 3	Plan 4	☐ Plan 5	Plan 6	
b. Specialist	b. Specialist Single Deductible Family Deductible Coinsurance Outpatient Facility Copayment Inpatient Facility Copayment Emergency Room Deductibles and out-of-pocket accumulation pe Additional Benefit Options: Please select optional prescription drug coverage Options Tier 1 Option 1 S15 copayment	'						
Single Deductible none none S1,000 S1,000 S2,000 N/A	Single Deductible none Family Deductible none Coinsurance none Dutpatient Facility Copayment S150 per incident facility Copayment confinement confinement state of the c	311 ner visit	'	· ·	'		'	
amily Deductible none none S2,000 S2,000 S4,000 N/A Coinsurance none none 80% to 90% to 90% to 90% to 10,000/S20,000 S10,000/S20,000 S10,000/	Family Deductible none Coinsurance none Dutpatient Facility Copayment S150 per incident facility S150 per conformation from the confinement confinement states and out-of-pocket accumulation per incident states and out-of-pocket accumulation states and out-of-pocket accumulation states and out-of-pocket accumu	20 por fiore	\$50 per visit	· ·	·	'	· ·	
Coinsurance none none none 80% to \$10,000/\$20,000 \$10,000/\$20,	Coinsurance none Dutpatient Facility Copayment S150 per incident patient Facility S150 per control confinement confinement S75 Deductibles and out-of-pocket accumulation per	one	none	\$1,000	\$1,000	\$2,000	N/A	
S10,000/S20,000 S10,000/S20,000/S20,000 S10,000/S20,000 S10,000/S2	Dutpatient Facility Copayment S150 per incident properties of the	one	none	\$2,000	\$2,000	\$4,000	N/A	
Dutpatient Facility Copayment S150 per incident S300 per incident S300 per incident Coinsurance Coinsura	npatient Facility Copayment Emergency Room S75 Deductibles and out-of-pocket accumulation per Additional Benefit Options: Please select optional prescription drug coverage Options Tier 1 Option 1 S10 copayment Option 2 S15 copayment	one	none	The state of the s			N/A	
Coinsurance	npatient Facility Copayment Copayment Confinement S75 Copayment Confinement S75 Copayment Copayment S75 Copayment Copayment S75 Copayment Copayment Copayment S10 copayment Copayment Copayment S10 copayment Copaym			\$10,000/\$20,000				
patient Facility confinement simergency Room S75	confinement confin	150 per incident	\$300 per incident				\$200 per incident	
Coinsurance Coinsurance Coinsurance Coinsurance Coinsurance Coinsurance finement imergency Room S75 S75 S75 S75 S75 S75 Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductional Benefit Options: Vision Dental Enhanced Dental Premium Other: Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductional Benefit Options: Vision Dental Enhanced Dental Premium Other: Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductible accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductible accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductible accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductible accumulation periods are on a calendar year contract year basis (plans 3-5 only). Inductible accumulation periods are on a calendar year calend	confinement confinement confinement confinement confinement confinement states and confinement states are confinement states and confinement states are confinement states are confinement				Coinsurance			
S75	Imergency Room S75 Reductibles and out-of-pocket accumulation penditional Benefit Options: Please select optional prescription drug coverage Options Tier 1 Option 1 \$10 copayment Option 2 \$15 copayment	'					\$200 per continuous co	
Peductibles and out-of-pocket accumulation periods are on a calendar year contract year basis (plans 3-5 only). Age 25 Dependent Student Cutoff (Age 23 is standard) Subject to Home Office Approval Note: Cutoff must match for all plan designs selected Mandated Offering - Dependent Age Extension to 29r Domestic Partner Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances Options Tier 1 Tier 2 Tier 3 Mail-Order Deductible** (Please select one)	lease select optional prescription drug coverage Options Tier 1 Option 1 \$10 copayment Option 2 \$15 copayment		1					
dditional Benefit Options: Vision	lease select optional prescription drug coverage	75	\$75	\$75	\$75	\$75	\$75	
□ 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 1 \$10 copayment ☐ Option 2 \$15 copayment		r 2	Tior Q	Mail_∩rdor	Naductibla** (P	lassa salast ana)	
□ Option 2 \$15 copayment 50% 50% 2x copayment or 50% □\$50 □\$100	Option 2 \$15 copayment							
	, , , ,		•	, ,				
I Intion 3* \$15 consyment \$311 consyment \$611 consyment \$311/\$617/\$181 \$101 (Required)	I Untion 3* S15 consyment	,		·		·		
		,		\$60 copayment				
□ Option 4 S15 copayment S35 copayment S75 copayment 2x copayment □\$50 □\$100			payment	, ,				
□ Waived N/A			/A	N/A	N/A	N/A	1	

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D. Oxford Ease (Non-gated - No referrals required)

otion		Plan 1			
payment: a. PCP b. Specialist		\$50 per visit \$50 per visit			
ngle Deductible		N/A			
ımily Deductible		N/A			
oinsurance		N/A			
utpatient Facility C	opayment	\$500 per incident			
patient Facility Cop	payment	\$500 per day, up to	a maximum of \$2,500 per calen	lar year	
nergency Room		\$150			
Iditional Benefit Op		Note: Cutoff must m ☐ Mandated Offering - ☐ Domestic Partner ☐ Coverage for Biologi	Dental Enhanced Student Cutoff (Age 23 is standariatch for all plan designs selected Dependent Age Extension so 29 cally Based Mental Illness and Ch	()	Other:Subject to Home Office Approval sturbances
	al prescription drug coverag	□ Age 25 Dependent : Note: Cutoff must m □ Mandated Offering - □ Domestic Partner □ Coverage for Biologi	Student Cutoff (Age 23 is standar atch for all plan designs selected Dependent Age Extension so 29	()	Subject to Home Office Approval
ease select optiona	al prescription drug coverag	□ Age 25 Dependent Note: Cutoff must m □ Mandated Offering - □ Domestic Partner □ Coverage for Biologi	Student Cutoff (Age 23 is standar atch for all plan designs selected Dependent Age Extension so 29 cally Based Mental Illness and Ch	l) Idren with Serious Emotional Dis	Subject to Home Office Approval
ease select optiona Options	al prescription drug coverag	□ Age 25 Dependent Note: Cutoff must m □ Mandated Offering - □ Domestic Partner □ Coverage for Biologi	Student Cutoff (Age 23 is standar atch for all plan designs selected Dependent Age Extension so 29 cally Based Mental Illness and Ch	l) Idren with Serious Emotional Dis Mail-Order	Subject to Home Office Approval sturbances Deductible* (Please select one)
ease select options Dptions Option 1 Waived Coverage	al prescription drug coverag Tier 1 \$15 copayment	□ Age 25 Dependent Note: Cutoff must m □ Mandated Offering □ Domestic Partner □ Coverage for Biologi e: Tier 2 \$35 copayment	Student Cutoff (Age 23 is standar atch for all plan designs selected Dependent Age Extension so 29 cally Based Mental Illness and Ch	ldren with Serious Emotional Dis Mail-Order 2x copayment	Subject to Home Office Approval sturbances Deductible* (Please select one) \$\infty\$
ease select options Dptions Option 1 Waived Coverage	al prescription drug coverag Tier 1 S15 copayment N/A	□ Age 25 Dependent Note: Cutoff must m □ Mandated Offering □ Domestic Partner □ Coverage for Biologi e: Tier 2 \$35 copayment	Student Cutoff (Age 23 is standar atch for all plan designs selected Dependent Age Extension so 29 cally Based Mental Illness and Ch	ldren with Serious Emotional Dis Mail-Order 2x copayment	Subject to Home Office Approval sturbances Deductible* (Please select one)
ease select options Options Option 1 Waived Coverage deductible applies to	al prescription drug coverage Tier 1 S15 copayment N/A to Tier 2 and Tier 3 drugs.	□ Age 25 Dependent Note: Cutoff must m □ Mandated Offering □ Domestic Partner □ Coverage for Biologi e: Tier 2 \$35 copayment	Student Cutoff (Age 23 is standar atch for all plan designs selected Dependent Age Extension so 29 cally Based Mental Illness and Ch	ldren with Serious Emotional Dis Mail-Order 2x copayment	Subject to Home Office Approval sturbances Deductible* (Please select one)

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E. Freedom Plan Direct and Liberty Plan Direct No referrals are required for these plan designs.

Please Select Netv In-Network/Out-of-Net		Freedom	☐ Liberty							
Options	☐ Plan 1	□ Plan 2	☐ Plan 3	□ Plan 4	☐ Plan 5	□ Plan 6	□ Plan 7	□ Plan 8	□ Plan 9	□ Plan 10
Copayment	\$15 PCP / \$25 Specialist	\$25 PCP / \$40 Specialis	\$25 PCP / \$40 Specialist	\$30 PCP / \$50 Specialist	N/A	N/A	N/A	N/A \$15 PCP / \$25 Specialist		\$25 PCP / \$40 Specialist
Single Deductible	\$500/\$1,000	\$500/\$1,000	\$1,000/\$2,000	\$2,000/\$2,000	\$500/\$1,000	\$2,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000	\$500/\$1,000	\$1,000/\$2,000
Family Deductible	\$1,000/\$2,000	\$1,000/\$2,00	0 \$2,000/\$4,000	\$4,000/\$4,000 \$1,000/\$2,00		\$4,000/\$4,000	\$2,000/\$4,000	\$2,000/\$4,000	\$1,000/\$2,000	\$2,000/\$4,000
Coinsurance	90%/70%	80%/60%	80%/60%	80%/60%	90%/70%	90%/70%	80%/60%	100%/70%	100%/70%	100%/70%
Out-of-Network Reimbursement - Freedom	150% of Medicare rate ³ Standard ¹ UCR	Medicare rate Standard UCR	3 Medicare rate ³	150% of Medicare rate ³ Standard ¹ UCR	150% of Medicare rate ³ Standard ¹ UCR	150% of Medicare rate ³ Standard ¹ UCR	150% of Medicare rate ³ Standard ¹ UCR	150% of Medicare rate ³ Standard ¹ UCR	150% of Medicare rate ³ Standard ¹ UCR	150% of Medicare rate Standard UCR
Out -of-Network Reimbursement - Liberty	140% of Medicare rate ²	140% of Medicare rate	140% of 2 Medicare rate ²	140% of Medicare rate ²	140% of Medicare rate ²	140% of Medicare rate ²	140% of Medicare rate ²	140% of Medicare rate ²	140% of Medicare rate ²	140% of Medicare rate
Single Maximum Out-of-Pocket	\$1,500/\$4,000	\$2,500/\$5,00	0 \$3,000/\$6,000	\$4,000/\$6,000	\$1,500/\$4,000	\$3,000/\$5,000	\$3,000/\$6,000	\$1,000/\$5,000	\$500/\$4,000	\$1,000/\$5,000
Family Maximum Out-of-Pocket	\$3,000/\$8,000	\$5,000/\$10,0	00 \$6,000/\$12,000	\$8,000/\$12,000	\$3,000/\$8,000	\$6,000/\$10,000	\$6,000/\$12,000	\$2,000/\$10,000	\$1,000/\$8,000	\$2,000/ \$10,000
Please select optional	proportation drug o		Age 25 Dependent S Note: Cutoff must ma Mandatory Offering - Domestic Partner Coverage for Biologic	atch for all plan des Dependent Age Ext	signs selected. tension to 29	ren with Serious Em	otional Disturbance		O HOME OFFICE AP	PROVAL
Options	Tie		Tier 2	I Tior	2 1	Mail-Order	I Do	eductible** (Please se	land and	
Ориона	116	11	1161 2	Tier 3		IVIAIITUTUBI	DE			
Option 1	\$10 cop	payment	ment \$25 copayment		ment	2x copayment	□ \$50 □ \$100 □ \$150 □ \$25		\$150 🗖 \$250	
Option 2	\$15 cop	oayment	50%	50%		2x copayment or 50%	□ \$5	\$50 🗖 \$100 🗖 \$150 🗖 \$2		
Option 3*	\$15 cop	oayment	\$30 copayment	\$60 copayı	ment	\$30/\$60/\$180		\$100 (Required)		
☐ Waived Coverag	e N <i>i</i>	/A	N/A	N/A		N/A		N/A		
**Deductible applies to Contraceptives:		,	of \$3,000, applicable	to all drugs.						
	No (Qualified Sta 28% Subsidy - For	the prescription	n plan design above, do	o you currently parti	cipate or plan to	participate with the 2	28% Government Si	ubsidy for your		

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F. Oxford MyPlan No referrals are required for these plan designs.

Please note: Groups enrolling in the Oxford MyPlan must also fill out an Oxford MyPlan Health Reserve Account Group Application Form (#6740).

Please Select Network:	Freedom	Libert
In-Network/Out-of-Network		

Please select a plan type:

Options	☐ Plan 1	☐ Plan 2	☐ Plan 3
Copayment	S25 PCP S40 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 - Freedom	☐ 150% of Medicare rate ³ ☐ Standard ¹ UCR	□ 150% of Medicare rate ³ □ Standard¹ UCR	□ 150% of Medicare rate ³ □ Standard ¹ UCR
Out-of-Network Reimbursement - Liberty	140% of Medicare rate ²	140% of Medicare rate ²	140% of Medicare rate ²
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

Additional Benefit Options:	☐ Vision	☐ Dental Enhanced	☐ Dental Premium	
☐ Age 25 Dependent Student Cutoff☐ Mandated Offering - Dependent Ag	,	te: Cutoff must match for all pla	n designs selected.	
☐ Domestic Partner		Biologically Based Mental Illness	and Children with Serious Emot	ional Disturbance

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order Deductib	6 ** (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.

Contraceptives:	☐ Yes (S	Standard) 🗖 No	(Qualified State Exempt G	Groups Only)	
Medicare Part D 28% Subsidy -	For the prescription plan	design above, do you d	urrently participate or plan	to participate with the	28% Government Subsidy for you
Medicare eligible retirees?	⊒ Yes □ No				

^{**} Deductible applies to Tier 2 and Tier 3 drugs.

Options		☐ Plan 1	☐ Plan 2	☐ Plan 3		
Single Deductible**		\$1,250	\$2,000	\$2,850		
amily Deductible**		\$2,500	\$4,000	\$5,700		
Coinsurance		100%	100%	100%		
ingle Medical Ma ut-of-Pocket	ximum	\$1,250	\$2,000	\$2,850		
amily Medical Ma ut-of-Pocket	aximum	\$2,500	\$4,000	\$5,700		
Cions Option 1	Tier 1 \$10 copayment	Tier 2 \$25 copayment	Tier \$50 copa		Mail-Order 2x copayment	
se select prescrip	otion drug coverage** (Rec	įuired):				
Option 1	\$10 copayment	\$25 copayment	\$50 copa	yment	2x copayment	
Option 2	\$15 copayment	50%	50%	Ď	2x copayment or 50%	
OTE: All in-network y based on the opt of-pocket have bee	ion selected at plan inception	n. No individual on a multiple	vork deductible. Once th	ie deductible has beei	n satisfied, the applicable medical coinsurance and prescription drug co ductible and maximum out-of-pocket until the entire family deductible o	ipayment will or maximum
NOTE: All in-network ply based on the opt t-of-pocket have bee t-of-network benefits	medical and pharmacy servi ion selected at plan inception on met. s are accumulated separately o Subsidy - For the prescrip	ices are subject to the in-netw n. No individual on a multiple v. otion plan design above, do y	vork deductible. Once th person contract may sa	e deductible has beer tisfy the individual der	n satisfied, the applicable medical coinsurance and prescription drug co ductible and maximum out-of-pocket until the entire family deductible of ate with the 28% Government Subsidy for your	ipayment will or maximum

H. Oxford HSA Direct No referrals are required for these plan designs.

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

Please	Select	Networ	k:	Freedom	Liberty

In-Network/Out-of-Network

Options	☐ Plan 1	□ Plan 2	☐ Plan 3	☐ Plan 4	☐ Plan 5	☐ Plan 6
Single	\$1,250/	\$2,000/	\$2,850/	\$1,250/	\$2,000/	\$2,850/
Deductible**	\$2,000	\$2,000	\$2,850	\$2,000	\$2,000	\$2,850
Family	\$2,500/	\$4,000/	\$5,700/	\$2,500/	\$4,000/	\$5,700/
Deductible**	\$4,000	\$4,000	\$5,700	\$4,000	\$4,000	\$5,700
Coinsurance	80%/60%	90%/70%	90%/70%	100%/70%	100%/70%	100%/70%
Out-of-Network Reimbursement - Freedom	Standard ¹ UCR					
Out-of-Network	140% of					
Reimbursement - Liberty	Medicare Rate ²					
Single Medical Maximum	\$3,250/	\$3,000/	\$3,850/	\$1,250/	\$2,000/	\$2,850/
Out-of-Pocket	\$6,000	\$5,000	\$5,850	\$5,000	\$5,000	\$5,850
Family Medical Maximum	\$6,500/	\$6,000/	\$7,700/	\$2,500/	\$4,000/	\$5,700/
Out-of-Pocket	\$12,000	\$10,000	\$11,700	\$10,000	\$10,000	\$11,700

Deductibles and out-of-pocket accumulation periods are on a 🖵 calendar year 🖵 contract year basis.						
Additional Benefit Options	3;	■ Vision □	■ Dental Enhanced	Dental Premium	Other:	
☐ Age 25 Depend	dent Student Cutoff (Age 23	is standard) Note: Cu	toff must match for all plan des	signs selected.		SUBJECT TO HOME OFFICE APPROVAL
☐ Mandated Offe	ring - Dependent Age Extens	ion to 29				
Domestic Partr	ner (□ Coverage for Biologica	lly Based Mental Illness and Ch	nildren with Serious Emotion	nal Disturbances	
Please select optional pro	escription drug coverage** (R	equired):				
Options	Tier 1	Tier 2	Tier 3	Mail-Order		

Options	Tier 1	Tier 2	Tier 3	Mail-Order
Option 1	\$10 copayment	\$25 copayment	\$50 copayment	2x copayment
Option 2	\$15 copayment	50%	50%	2x copayment or 50%

|--|

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

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^{**}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 have been met.

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
\$	\$	\$	\$

BROKER/AGENT INFORMATION **Broker** Co-Broker **General Agent** Name of Payee: Payee's Oxford Broker Code (Required): Payee's Social Security # or Federal Tax ID # : Name of Writing Agent (Required if Payee is a company): Writing Agent's Oxford Broker Code (Required if Payee is a company): Commission Split %: 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	e effective immediately a	and shall (check one only):	
	Remain in place until i	is expressly revoked by me in wr	iting
	Remain in place until		
		DATE	

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

I acknowledge that I must notify Oxford in writing to void this agreement in the event of a change in my company's Broker of Record.

	VII. COBRA & EXTENSION OF BENEFITS DATA
1.	Do you have any individuals currently on COBRA continuation?
2.	Are there any dependents of employees who are currently disabled or in the hospital?
	What is the length of the prior carrier's extension of benefits period for disabled employees or dependents?
	VIII. APPLICANT AGREEMENT
chai to o curr	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, ges 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 fer 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 ently 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 red 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.
Date	d at:day of
The Any conf	above named company confirms that we employ no more than 50 full-time, non-union employees. person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim aining any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also ubject to a civil penalty not to exceed \$5,000 dollars and the stated value of the claim for each such violation.
Ox X	ford Health Insurance, Inc.
Signa	ure of Authorized Officer of the Company Title
Witn	SS Duly Licensed Resident Agent/Broker