UnitedHealthcare®
Oxford

New Jersey Application for a Small Group Health Benefits Policy – OHI

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

Please print or type

Policy Number (OHI Use Only): _____

❑ **New Policy** ❑ **Change in Policy** **Requested Effective Date:**_____

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

I. POLICYHOLDER INFORMATION

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

2. **Tax Identification Number:**

3. **Main Address:** Street / City / State / ZIP Code

Mailing Address: Street / City / State / ZIP Code

Telephone and Facsimile: Fax

E-Mail address _____

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

4. **Name of Correspondent:**

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

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

7. **Number of full-time employees in your company:**_____
Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.

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

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

10. **Insurance Requested For:** ❑ Employees Only ❑ Employees and Dependents including Spouse
❑ Employees and Dependents excluding Spouse

Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c.246 ❑ Yes ❑ No
If yes, should the plan provide coverage for children of a covered domestic partner? ❑ Yes ❑ No

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

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

I. POLICYHOLDER INFORMATION (CONTINUED)

13. Orientation Period: ❑ Yes ❑ No

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

Present employees _____ New or rehired employees_____

15. Period for Annual Employee Open Enrollment Period:_____

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

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

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

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

Legal Name and Location	Number of full-time employees in this company	Number of full-time employees to be insured

II. SPECIFICATIONS FOR COVERAGE

PLEASE SELECT A PLAN FROM SECTION A, B, C OR D.

A. PLATINUM PLANS

Option	❑ NJ P LBTY NG 15/40/100 EPO 18	❑ NJ P FRDM NG 15/40/100 EPO 18	❑ NJ P LBTY NG 20/40/100 PPO 18 -1	❑ NJ P FRDM NG 20/40/100 PPO 18 -1
Network	Liberty	Freedom	Liberty	Freedom
Access	Non-gated	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $15 per visit $40 per visit	 $15 per visit $40 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	N/A
In-Network Maximum Out-of-Pocket (Single/Family)	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000
In-Network Coinsurance	N/A	N/A	N/A	N/A
Outpatient Facility Copayment	Freestanding Facility – $40 Hospital Facility – $150	Freestanding Facility – $40 Hospital Facility – $150	Freestanding Facility – $40 Hospital Facility – $150	Freestanding Facility – $40 Hospital Facility – $150
Inpatient Facility Copayment	$250 per day to $1,250 maximum per admit ($2,500 maximum per year)	$250 per day to $1,250 maximum per admit ($2,500 maximum per year)	$100 per day to $500 maximum per admit ($1,000 maximum per year)	$100 per day to $500 maximum per admit ($1,000 maximum per year)
Emergency Room	$100	$100	$100	$100
Out-of-Network Deductible (Single/Family)	N/A	N/A	$2,000/$4,000	$2,000/$4,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	N/A	$5,000/$10,000	$5,000/$10,000
Out-of-Network Coinsurance	N/A	N/A	30%	30%
Prescription Drug Coverage	Tier 1 – $5 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $5 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $5 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $5 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A

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

Additional Benefit Options:

❑ Domestic Partner

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

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

A. PLATINUM PLANS (CONTINUED)

Option	❑ NJ P LBTY NG 15/45/100 PPO 18	❑ NJ P FRDM NG 15/45/100 PPO 18	❑ NJ P LBTY NG 20/40/100 PPO 18 -2	❑ NJ P FRDM NG 20/40/100 PPO 18 -2
Network	Liberty	Freedom	Liberty	Freedom
Access	Non-gated	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $15 per visit $45 per visit	 $15 per visit $45 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	N/A
In-Network Maximum Out-of-Pocket (Single/Family)	$2,750/$5,500	$2,750/$5,500	$2,000/$4,000	$2,000/$4,000
In-Network Coinsurance	N/A	N/A	N/A	N/A
Outpatient Facility Copayment	Freestanding Facility – No charge Hospital Facility – $150	Freestanding Facility – No charge Hospital Facility – $150	Freestanding Facility – $10 Hospital Facility – $150	Freestanding Facility – $10 Hospital Facility – $150
Inpatient Facility Copayment	$300 per day to $1,500 maximum per admit ($3,000 maximum per year)	$300 per day to $1,500 maximum per admit ($3,000 maximum per year)	$200 per day to a max of $1000 per admit ($2000 max per year)	$200 per day to a max of $1000 per admit ($2000 max per year)
Emergency Room	$100	$100	$100	$100
Out-of-Network Deductible (Single/Family)	$2,500/$5,000	$2,500/$5,000	$2,000/$4,000	$2,000/$4,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	$6,250/$12,500	$6,250/$12,500	$5,000/$10,000	$5,000/$10,000
Out-of-Network Coinsurance	30%	30%	30%	30%
Prescription Drug Coverage	Tier 1 – $5 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $5 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $5 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $5 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A

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

Additional Benefit Options:
❑ Domestic Partner

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

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

B. GOLD PLANS

Option	❑ NJ G LBTY NG 50/50/600/100 EPO 18	❑ NJ G LBTY GT 50/50/600/100 EPO 18	❑ NJ G FRDM NG 50/50/600/100 EPO 18	❑ NJ G FRDM GT 50/50/600/100 EPO 18
Network	Liberty	Liberty	Freedom	Freedom
Access	Non-gated	Gated*	Non-gated	Gated*
Copayment: **a. PCP** **b. Specialist**	 $50 per visit $50 per visit	 $50 per visit $50 per visit	 $50 per visit $50 per visit	 $50 per visit $50 per visit
In-Network Deductible (Single/Family)	$600/$1,200	$600/$1,200	$600/$1,200	$600/$1,200
In-Network Maximum Out-of-Pocket (Single/Family)	$4500/$9000	$4500/$9000	$4500/$9000	$4500/$9000
In-Network Coinsurance	N/A	N/A	N/A	N/A
Outpatient Facility Copayment	Freestanding Facility – $50 Hospital Facility – 50%	Freestanding Facility – $50 Hospital Facility – 50%	Freestanding Facility – $50 Hospital Facility – 50%	Freestanding Facility – $50 Hospital Facility – 50%
Inpatient Facility Copayment	$500 per day to $2500 maximum per admit ($5000 maximum per year)	$500 per day to $2500 maximum per admit ($5000 maximum per year)	$500 per day to $2500 maximum per admit ($5000 maximum per year)	$500 per day to $2500 maximum per admit ($5000 maximum per year)
Emergency Room	$100 then deductible	$100 then deductible	$100 then deductible	$100 then deductible
Prescription Drug Coverage	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

B. GOLD PLANS (CONTINUED)

Option	❑ NJ G LBTY NG 30/50/1000/80 EPO 18	❑ NJ G LBTY GT 30/50/1000/80 EPO 18	❑ NJ G LBTY NG 25/40/1250/80 EPO 18
Network	Liberty	Liberty	Liberty
Access	Non-gated	Gated*	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $30 per visit $50 per visit	 $30 per visit $50 per visit	 $25 per visit $40 per visit
In-Network Deductible (Single/ Family)	$1,000/$2,000	$1,000/$2,000	$1,250/$2,500
In-Network Maximum Out-of-Pocket (Single/Family)	$3,500/$7,000	$3,500/$7,000	$4,200/$8,400
In-Network Coinsurance	20%	20%	20%
Outpatient Facility Copayment	Freestanding Facility – $75 Hospital Facility – $150	Freestanding Facility – $75 Hospital Facility – $150	Freestanding Facility – $50 Hospital Facility – $150
Inpatient Facility Copayment	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	$100 then deductible and coinsurance.	$100 then deductible and coinsurance.	$100 then deductible and coinsurance.
Prescription Drug Coverage	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

B. GOLD PLANS (CONTINUED)

Option	❑ NJ G LBTY NG 25/50/750/50 EPO 18	❑ NJ G LBTY NG 30/50/2000/70 EPO 18	❑ NJ G LBTY NG 20/40/1500/70 EPO 18
Network	Liberty	Liberty	Liberty
Access	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $25 per visit $50 per visit	 $30 per visit $50 per visit	 $20 per visit $40 per visit
In-Network Deductible (Single/Family)	$750/$1,500	$2,000/$4,000	$1,500/$3,000
In-Network Maximum Out-of-Pocket (Single/Family)	$4,500/$9,000	$5,000/$10,000	$5,000/$10,000
In-Network Coinsurance	50%	30%	30%
Outpatient Facility Copayment	Freestanding Facility – $75 Hospital Facility – $150	Freestanding Facility – $50 Hospital Facility – $150	Deductible and coinsurance
Inpatient Facility Copayment	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	$100 then deductible and coinsurance.	$100 then deduct and coinsurance	$100 then coinsurance
Out-of-Network Deductible (Single/Family)	N/A	N/A	N/A
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	N/A	N/A
Out-of-Network Coinsurance	N/A	N/A	N/A
Prescription Drug Coverage	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 - $20 copayment Tier 2 - $50 copayment Tier 3 - $75 copayment Mail Order - 2x copay Deductible - N/A

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

B. GOLD PLANS (CONTINUED)

Option	❑ NJ G LBTY NG 25/40/1000/80 PPO 18	❑ NJ G FRDM NG 25/40/1000/80 PPO 18	❑ NJ G LBTY NG 30/50/1500/80 PPO 18	❑ NJ G FRDM NG 30/50/1500/80 PPO 18
Network	Liberty	Freedom	Liberty	Freedom
Access	Non-gated	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $25 per visit $40 per visit	 $25 per visit $40 per visit	 $30 per visit $50 per visit	 $30 per visit $50 per visit
In-Network Deductible (Single/Family)	$1,000/$2,000	$1,000/$2,000	$1,500/$3,000	$1,500/$3,000
In-Network Maximum Out-of-Pocket (Single/Family)	$4,800/$9,600	$4,800/$9,600	$3,750/$7,500	$3,750/$7,500
In-Network Coinsurance	20%	20%	20%	20%
Outpatient Facility Copayment	Freestanding Facility – Deductible then 20% Hospital Facility – Deductible then 50%	Freestanding Facility – Deductible then 20% Hospital Facility – Deductible then 50%	Freestanding Facility – Deductible then 20% Hospital Facility – Deductible then 50%	Freestanding Facility – Deductible then 20% Hospital Facility – Deductible then 50%
Inpatient Facility Copayment	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	$100 then deductible and coinsurance.	$100 then deductible and coinsurance.	$100 then deductible and coinsurance	$100 then deductible and coinsurance
Out-of-Network Deductible (Single/Family)	$3,000/$6,000	$3,000/$6,000	$4,000/$8,000	$4,000/$8,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	$7,500/$15,000	$7,500/$15,000	$9,000/$18,000	$9,000/$18,000
Out-of-Network Coinsurance	40%	40%	40%	40%
Prescription Drug Coverage	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $10 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $10 copayment Tier 2 – $25 copayment Tier 3 – $50 copayment Mail-Order – 2x copay Deductible – N/A

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

* Referrals are required for this plan design.

Additional Benefit Options:

❑ Domestic Partner

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

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

B. GOLD PLANS (CONTINUED)

Option	❑ NJ G LBTY NG 30/50/2000/50 EPO 18	❑ NJ G LBTY NG 35/60/1500/70 PPO 18	❑ NJ G LBTY NG 30/50/70 PPO 18
Network	Liberty	Liberty	Liberty
Access	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $30 per visit after deduct $50 per visit after deduct	 $35 per visit after deduct $50 per visit after deduct	 $30 per visit after deduct $50 per visit after deduct
In-Network Deductible (Single/Family)	$2,000/$4,000	$1,500/$3,000	N/A
In-Network Maximum Out-of-Pocket (Single/Family)	$7,150/$14,300	$7,150/$14,300	$6,000/$12,000
In-Network Coinsurance	50%	30%	30%
Outpatient Facility Copayment	Deductible and coinsurance	Deductible and coinsurance	30%
Inpatient Facility Copayment	Deductible and Coinsurance	Deductible and Coinsurance	30%
Emergency Room	$100 then coinsurance	$100 then coinsurance	$100 then coinsurance
Out-of-Network Deductible (Single/Family)	N/A	$4,500/$9,000	$5,000/10,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	$10,000/$20,000	$10,000/$20,000
Out-of-Network Coinsurance	N/A	50%	50%
Prescription Drug Coverage	Tier 1 - $20 copayment Tier 2 - $50 copayment Tier 3 - $75 copayment Mail Order - 2x copay Deductible - N/A	Tier 1 - $20 copayment Tier 2 - $50 copayment Tier 3 - $75 copayment Mail Order - 2x copay Deductible - N/A	Tier 1 - $20 copayment Tier 2 - $50 copayment Tier 3 - $75 copayment Mail Order - 2x copay Deductible - N/A

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

* Referrals are required for this plan design.

Additional Benefit Options:

❑ Domestic Partner

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

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

C. SILVER PLANS

Option	❑ NJ S LBTY NG 30/50/2000/80 EPO HSA 18	❑ NJ S LBTY NG 40/75/2500/50 EPO 18	❑ NJ S LBTY NG 50/75/2500/70 PPO 18	❑ NJ S FRDM NG 50/75/2500/70 PPO 18
Network	Liberty	Liberty	Liberty	Freedom
Access	Non-gated	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 Deductible then $30 Deductible then $50	 $40 per visit $75 per visit	 $50 per visit $75 per visit	 $50 per visit $75 per visit
In-Network Deductible (Single/Family)	$2,000/$4,000	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000
In-Network Maximum Out-of-Pocket (Single/Family)	$6,550/$13,100	$6,850/$13,700	$7,200/$14,400	$7,200/$14,400
In-Network Coinsurance	20%	50%	30%	30%
Outpatient Facility Copayment	Freestanding Facility – Deductible then no charge Hospital Facility – Deductible then $500	Freestanding Facility – Deductible then 30% Coinsurance Hospital Facility – Deductible then 50% Coinsurance	Freestanding Facility – Deductible then 30% Coinsurance Hospital Facility – Deductible then 50% Coinsurance	Freestanding Facility – Deductible then 30% Coinsurance Hospital Facility – Deductible then 50% Coinsurance
Inpatient Facility Copayment	Deductible then $500 per day ($1,500 max per year)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	Deductible then $100 then coinsurance	$100 then deductible and coinsurance	$100 then deductible and coinsurance	$100 then deductible and coinsurance
Out-of-Network Deductible (Single/Family)	N/A	N/A	$5,000/$10,000	$5,000/$10,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	N/A	$12,500/$25,000	$12,500/$25,000
Out-of-Network Coinsurance	N/A	N/A	50%	50%
Prescription Drug Coverage	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible**	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible – N/A

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

* 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. 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

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

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

C. SILVER PLANS

Option	❑ NJ S FRDM NG 2500/100 PPO HSA 18	❑ NJ S LBTY NG 20/40/2000/60 PPO HSA 18
Network	Freedom	Liberty
Access	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 Deductible then no charge Deductible then no charge	 $20 per visit after deduct $40 per visit after deduct
In-Network Deductible (Single/Family)	$2,500/$5,000	$2,000/$4,000
In-Network Maximum Out-of-Pocket (Single/ Family)	$6,850/$13,700	$6,000/$12,000
In-Network Coinsurance	100%	40%
Outpatient Facility Copayment	Deductible then no charge (Freestanding and Hospital)	Deductible then $200 (Freestanding/Hospital)
Inpatient Facility Copayment	$500 per day after deductible. $1500 max per year.	$400 per day after deductible. $2000 max per year.
Emergency Room	$100 then deductible and coinsurance	$100 then deductible and coinsurance
Out-of-Network Deductible (Single/Family)	$5,000/$10,000	$4,000/$8,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	$13,700/$27,400	$8,000/$16,000
Out-of-Network Coinsurance	50%	50%
Prescription Drug Coverage	Tier 1 - $7 copayment Tier 2 - 50% Tier 3 - 50% Mail-Order - 2x copay Deductible**	Tier 1 - $20 copayment Tier 2 - $50 copayment Tier 3 - $75 copayment Mail-Order - 2x copay Deductible**

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

* 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. 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

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

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

D. BRONZE PLANS

Option	❑ NJ B LBTY NG 3000/50 EPO HSA 18	❑ NJ B LBTY NG 10/70/3000/50 EPO HSA 18
Network	Liberty	Liberty
Access	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 Deductible then 50% Coinsurance	 Deductible then $10 per visit Deductible then $70 per visit
In-Network Deductible (Single/Family)	$3,000/$6,000	$3,000/$6,000
In-Network Maximum Out-of-Pocket (Single/Family)	$6,550/$13,100	$6,550/$13,100
In-Network Coinsurance	50%	50%
Outpatient Facility Copayment	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Facility Copayment	$100 per day to $500 maximum per admit ($1000 maximum per year)	$50 per day to $250 maximum per admit ($500 maximum per year)
Emergency Room	Deductible then $100 then coinsurance	Deductible then $100 then coinsurance
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 – 50% Tier 2 – 50% Tier 3 – 50% Mail-Order – 2x copay Deductible**	Tier 1 – 50% Tier 2 – 50% Tier 3 – 50% Mail-Order – 2x copay Deductible**

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

**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

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

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

E. GARDEN STATE PLANS

Option	❑ NJ P GDST NG 10/40/100 EPO 18	❑ NJ P GDST NG 20/40/100 EPO 18	❑ NJ P GDST NG 10/30/90 EPO 18	❑ NJ G GDST NG 1500/100 EPO HSA 18
Network	Garden State	Garden State	Garden State	Garden State
Access	Non-gated	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $10 per visit $40 per visit	 $20 per visit $40 per visit	 $10 per visit $30 per visit	 Deductible then no charge Deductible then no charge
In-Network Deductible (Single/Family)	N/A	N/A	N/A	$1,500/$3,000
In-Network Maximum Out-of-Pocket (Single/Family)	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000	$4,000/$8,000
In-Network Coinsurance	N/A	N/A	100%	N/A
Outpatient Facility Copayment	Freestanding Facility – $50 Hospital Facility – $150	Freestanding Facility – $50 Hospital Facility – $150	Freestanding: $150 Hospital: $300	Freestanding Facility – Deductible then no charge Hospital Facility – Deductible then no charge
Inpatient Facility Copayment	$200 per day to $800 maximum per admit	$250 per day to $1,000 maximum per admit	90%	Deductible then no charge
Emergency Room	$100	$100	$100	Deductible then $100.
Prescription Drug Coverage	Tier 1 – $5 copayment Tier 2 – $35 copayment Tier 3 – $60 copayment Mail-Order – 2x copay Deductible - $100***	Tier 1 – $5 copayment Tier 2 – $35 copayment Tier 3 – $60 copayment Mail-Order – 2x copay Deductible - $100***	Tier 1 - $5 copayment Tier 2 - $25 copayment Tier 3 - $50 copayment Mail Order - 2x copay Deductible - N/A	Tier 1 – $15 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment Mail-Order – 2x copay Deductible**

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

E. GARDEN STATE PLANS (CONTINUED)

Option	❑ NJ G GDST NG 25/50/1000/90 EPO 18	❑ NJ G GDST NG 25/50/1250/80 EPO 18	❑ NJ G GDST NG 25/50/500/50 EPO 18	❑ NJ G GDST NG 30/60/2000/70 EPO 18
Network	Garden State	Garden State	Garden State	Garden State
Access	Non-gated	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $25 per visit Deductible then $50 per visit	 $25 per visit $50 per visit	 $25 per visit $50 per visit	 $30 per visit $60 per visit
In-Network Deductible (Single/Family)	$1,000/$2,000	$1,250/$2,500	$500/$1,000	$2,000/$4,000
In-Network Maximum Out-of-Pocket (Single/Family)	$3,000/$6,000	$3,300/$6,600	$4,750/$9,500	$6,850/$13,700
In-Network Coinsurance	10%	20%	50%	30%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $75 Hospital Facility – Deductible then $150	Freestanding Facility – $75 Hospital Facility – $150	Freestanding Facility – $125 Hospital Facility – $250	Deductible then Coinsurance (Freestanding and Hospital)
Inpatient Facility Copayment	$250 per day to $1,250 maximum per admit ($2500 maximum per year)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	$100 then Deductible and Coinsurance	$100 then Deductible and Coinsurance	$100 then Deductible and Coinsurance	$100 then Deductible and Coinsurance
Prescription Drug Coverage	Tier 1 – $10 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment Mail-Order – 2x copay Deductible***	Tier 1 – $10 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment Mail-Order – 2x copay Deductible - $100***	Tier 1 – $10 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment Mail-Order – 2x copay Deductible - $100***	Tier 1 - $15 copayment Tier 2 - $35 copayment Tier 3 - $75 copayment Mail Order - 2x copay Deductible - N/A

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

E. GARDEN STATE PLANS (CONTINUED)

Option	❑ NJ S GDST NG 25/50/2000/80 EPO HSA 18	❑ NJ S GDST NG 40/75/2250/50 EPO 18	❑ NJ S GDST NG 50/75/2400/70 EPO 18	❑ NJ S GDST GT 50/75/2400/70 EPO 18
Network	Garden State	Garden State	Garden State	Garden State
Access	Non-gated	Non-gated	Non-gated	Gated*
Copayment: **a. PCP** **b. Specialist**	 Deductible then $25 per visit Deductible then $50 per visit	 $40 per visit $75 per visit	 $50 per visit $75 per visit	 $50 per visit $75 per visit
In-Network Deductible (Single/Family)	$2,000/$4,000	$2,250/$4,500	$2,400/$4,800	$2,400/$4,800
In-Network Maximum Out-of-Pocket (Single/Family)	$6,550/$13,100	$7,100/$14,200	$7,200/$14,400	$7,200/$14,400
In-Network Coinsurance	20%	50%	30%	30%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $75 Hospital Facility – Deductible then $500	Freestanding Facility – Deductible then 30% Coinsurance Hospital Facility – Deductible then 50% Coinsurance	Freestanding Facility – Deductible then 30% Hospital Facility – Deductible then 50%	Freestanding Facility – Deductible then 30% Hospital Facility – Deductible then 50%
Inpatient Facility Copayment	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room	Deductible then $100 then coinsurance.	$100 then Deductible and Coinsurance	$100 then Deductible and Coinsurance	$100 then Deductible and Coinsurance
Prescription Drug Coverage	Tier 1 – $10 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment Mail-Order – 2x copay Deductible**	Tier 1 – $10 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment Mail-Order – 2x copay Deductible $100***	Tier 1 – $10 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment Mail-Order – 2x copay Deductible - $100***	Tier 1 – $10 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment Mail-Order – 2x copay Deductible - $100***

II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

E. GARDEN STATE PLANS (CONTINUED)

Option	❑ NJ S GDST NG 40/60/2000/90 EPO 18*	❑ NJ S GDST NG 1750/60 EPO HSA 18	❑ NJ B GDST NG 10/70/3000/50 EPO HSA 18	❑ NJ B GDST NG 3000/50 EPO HSA 18
Network	Garden State	Garden State	Garden State	Garden State
Access	Non-gated	Non-gated	Non-gated	Non-gated
Copayment: **a. PCP** **b. Specialist**	 $40 per visit $60 per visit after deductible	 Deductible then 60% Deductible then 60%	 $10 per visit after deductible $70 per visit after deductible	 Deductible then 50% Coinsurance
In-Network Deductible (Single/Family)	$2,000/$4,000	$1,750/$3,500	$3,000/$6,000	$3,000/$6,000
In-Network Maximum Out-of-Pocket (Single/Family)	$6,600/$13,200	$7,350/$14,700	$6,550/$13,100	$6,550/$13,100
In-Network Coinsurance	10%	40%	50%	50%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $100 Hospital Facility – Deductible then $300	Deductible then Coinsurance (Freestanding and Hospital)	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Inpatient Facility Copayment	Deductible then $500 per day to $2500 maximum per admit ($5000 maximum per year)	Deductible then $500 per day ($1500 maximum per year)	Deductible then $50 per day to $250 maximum per admit ($500 maximum per year)	Deductible then $100 per day to $500 maximum per admit ($1,000 maximum per year)
Emergency Room	$100 then Deductible and Coinsurance	$100 then deductible and coinsurance	Deductible then $100 then coinsurance.	Deductible then $100 then coinsurance.
Prescription Drug Coverage	Tier 1 – $25 copayment Tier 2 – $50 copayment Tier 3 – $75 copayment Mail-Order – 2x copay Deductible***	Tier 1 - $7 copayment Tier 2 - 50% Tier 3 - 50% Mail-Order - 2x copay Deductible**	Tier 1 – 50% Tier 2 – 50% Tier 3 – 50% Mail-Order – 2x copay Deductible**	Tier 1 – 50% Tier 2 – 50% Tier 3 – 50% Mail-Order – 2x copay Deductible**

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

* 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. 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.

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

Additional Benefit Options:

❑ Domestic Partner

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

III. ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:

   Now in force and to be continued? ❑ Yes ❑ No

   Currently being applied for? ❑ Yes ❑ No

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

   _____

2. Name of present or prior group carrier: _____

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

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

   If "Yes" give reason _____

   Plan being replaced: _____

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

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

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

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

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

5. To the best of your knowledge:

   A. Are any employees or dependents presently incapacitated? ❑ Yes ❑ No

   B. Are any dependent children incapable of self-support due to a physical or mental disability? ❑ Yes ❑ No

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

_____

_____

_____

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

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

IV. AGENT/PRODUCER INFORMATION

Broker: _____ _____

Name Code Address

Broker: _____ _____

Name Code Address

V. SIGNATURE

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

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

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

Dated at:_____on_____

_____ Print Name of Officer, Partner or Proprietor

_____ Signature of Officer, Partner or Proprietor

_____ Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification