



## 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, D, OR E.

### A. PLATINUM PLANS

Option	<input type="checkbox"/> NJ P LBTY NG 15/40/100 EPO 19	<input type="checkbox"/> NJ P FRDM NG 15/40/100 EPO 19	<input type="checkbox"/> NJ P LBTY NG 20/40/500/100 PPO 19	<input type="checkbox"/> NJ P FRDM NG 20/40/500/100 PPO 19
<b>Network</b>	Liberty	Freedom	Liberty	Freedom
<b>Access</b>	Non-gated	Non-gated	Non-gated	Non-gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$15 per visit \$40 per visit	\$15 per visit \$40 per visit	\$20 per visit \$40 per visit	\$20 per visit \$40 per visit
<b>In-Network Deductible (Single/Family)</b>	N/A	N/A	\$500/\$1,000	\$500/\$1,000
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000
<b>In-Network Coinsurance</b>	N/A	N/A	N/A	N/A
<b>Outpatient Facility Copayment</b>	Freestanding Facility – \$40 Hospital Facility – \$150	Freestanding Facility – \$40 Hospital Facility – \$150	Freestanding Facility – \$40 Hospital Facility – \$150	Freestanding Facility – \$40 Hospital Facility – \$150
<b>Inpatient Facility Copayment</b>	\$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)
<b>Emergency Room</b>	\$100	\$100	\$100	\$100
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A	\$2,000/\$4,000	\$2,000/\$4,000
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A	\$5,000/\$10,000	\$5,000/\$10,000
<b>Out-of-Network Coinsurance</b>	N/A	N/A	30%	30%
<b>Prescription Drug Coverage</b>	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	<input type="checkbox"/> NJ P LBTY NG 15/45/100 PPO 19	<input type="checkbox"/> NJ P FRDM NG 15/45/100 PPO 19	<input type="checkbox"/> NJ P LBTY NG 20/40/100 PPO 19	<input type="checkbox"/> NJ P FRDM NG 20/40/100 PPO 19
<b>Network</b>	Liberty	Freedom	Liberty	Freedom
<b>Access</b>	Non-gated	Non-gated	Non-gated	Non-gated
<b>Copayment:</b>				
<b>a. PCP</b>	\$15 per visit	\$15 per visit	\$20 per visit	\$20 per visit
<b>b. Specialist</b>	\$45 per visit	\$45 per visit	\$40 per visit	\$40 per visit
<b>In-Network Deductible (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$2,750/\$5,500	\$2,750/\$5,500	\$2,250/\$4,500	\$2,250/\$4,500
<b>In-Network Coinsurance</b>	N/A	N/A	N/A	N/A
<b>Outpatient Facility Copayment</b>	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
<b>Inpatient Facility Copayment</b>	\$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 \$1,000 maximum per admit (\$2000 maximum per year)	\$200 per day to \$1,000 maximum per admit (\$2000 maximum per year)
<b>Emergency Room</b>	\$100	\$100	\$100	\$100
<b>Out-of-Network Deductible (Single/Family)</b>	\$2,500/\$5,000	\$2,500/\$5,000	\$2,000/\$4,000	\$2,000/\$4,000
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	\$6,250/\$12,500	\$6,250/\$12,500	\$5,000/\$10,000	\$5,000/\$10,000
<b>Out-of-Network Coinsurance</b>	30%	30%	30%	30%
<b>Prescription Drug Coverage</b>	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	<input type="checkbox"/> NJ G LBTY NG 50/50/600/100 EPO 19	<input type="checkbox"/> NJ G LBTY GT 50/50/600/100 EPO 19	<input type="checkbox"/> NJ G FRDM NG 50/50/600/100 EPO 19	<input type="checkbox"/> NJ G FRDM GT 50/50/600/100 EPO 19
<b>Network</b>	Liberty	Liberty	Freedom	Freedom
<b>Access</b>	Non-gated	Gated	Non-gated	Gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$50 per visit \$50 per visit	\$50 per visit \$50 per visit	\$50 per visit \$50 per visit	\$50 per visit \$50 per visit
<b>In-Network Deductible (Single/Family)</b>	\$600/\$1,200	\$600/\$1,200	\$600/\$1,200	\$600/\$1,200
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$7,500/\$15,000	\$7,500/\$15,000	\$7,500/\$15,000	\$7,500/\$15,000
<b>In-Network Coinsurance</b>	N/A	N/A	N/A	N/A
<b>Outpatient Facility Copayment</b>	Freestanding Facility – \$50 Hospital Facility – 50%	Freestanding Facility – \$50 Hospital Facility – 50%	Freestanding Facility – \$50 Hospital Facility – 50%	Freestanding Facility – \$50 Hospital Facility – 50%
<b>Inpatient Facility Copayment</b>	\$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)
<b>Emergency Room</b>	\$100 then deductible then 50%	\$100 then deductible then 50%	\$100 then deductible then 50%	\$100 then deductible then 50%
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>Out-of-Network Coinsurance</b>	N/A	N/A	N/A	N/A
<b>Prescription Drug Coverage</b>	Tier 1 – \$10 copayment Tier 2 – \$50 copayment Tier 3 – \$75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – \$10 copayment Tier 2 – \$50 copayment Tier 3 – \$75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – \$10 copayment Tier 2 – \$50 copayment Tier 3 – \$75 copayment Mail-Order – 2x copay Deductible – N/A	Tier 1 – \$10 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	<input type="checkbox"/> NJ G LBTY NG 30/50/1000/80 EPO 19	<input type="checkbox"/> NJ G LBTY GT 30/50/1000/80 EPO 19	<input type="checkbox"/> NJ G LBTY NG 25/40/1250/80 EPO 19
<b>Network</b>	Liberty	Liberty	Liberty
<b>Access</b>	Non-gated	Gated	Non-gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$30 per visit \$50 per visit	\$30 per visit \$50 per visit	\$25 per visit \$40 per visit
<b>In-Network Deductible (Single/ Family)</b>	\$1,000/\$2,000	\$1,000/\$2,000	\$1,250/\$2,500
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$4,250/\$8,500	\$4,250/\$8,500	\$4,200/\$8,400
<b>In-Network Coinsurance</b>	20%	20%	20%
<b>Outpatient Facility Copayment</b>	Freestanding Facility – \$75 Hospital Facility – \$150	Freestanding Facility – \$75 Hospital Facility – \$150	Freestanding Facility – \$50 Hospital Facility – \$150
<b>Inpatient Facility Copayment</b>	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
<b>Emergency Room</b>	\$100 then deductible and coinsurance.	\$100 then deductible and coinsurance.	\$100 then deductible and coinsurance.
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A	N/A
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A	N/A
<b>Out-of-Network Coinsurance</b>	N/A	N/A	N/A
<b>Prescription Drug Coverage</b>	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	<input type="checkbox"/> NJ G LBTY NG 25/50/750/50 EPO 19	<input type="checkbox"/> NJ G LBTY NG 30/50/2000/70 EPO 19	<input type="checkbox"/> NJ G LBTY NG 20/40/1500/70 EPO 19
<b>Network</b>	Liberty	Liberty	Liberty
<b>Access</b>	Non-gated	Non-gated	Non-gated
<b>Copayment:</b> a. PCP b. Specialist	\$25 per visit \$50 per visit	\$30 per visit \$50 per visit	\$20 per visit \$40 per visit
<b>In-Network Deductible (Single/Family)</b>	\$750/\$1,500	\$2,000/\$4,000	\$1,500/\$3,000
<b>In-Network Maximum Out- of-Pocket (Single/Family)</b>	\$4,500/\$9,000	\$5,000/\$10,000	\$5,000/\$10,000
<b>In-Network Coinsurance</b>	50%	30%	30%
<b>Outpatient Facility Copayment</b>	Freestanding Facility – \$75 Hospital Facility – \$150	Freestanding Facility – \$50 Hospital Facility – \$150	Deductible and coinsurance
<b>Inpatient Facility Copayment</b>	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
<b>Emergency Room</b>	\$100 then deductible and coinsurance.	\$100 then deduct and coinsurance	\$100 then coinsurance
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A	N/A
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A	N/A
<b>Out-of-Network Coinsurance</b>	N/A	N/A	N/A
<b>Prescription Drug Coverage</b>	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	<input type="checkbox"/> NJ G LBTY NG 25/40/1000/80 PPO 19	<input type="checkbox"/> NJ G FRDM NG 25/40/1000/80 PPO 19	<input type="checkbox"/> NJ G LBTY NG 30/65/1500/80 PPO 19	<input type="checkbox"/> NJ G FRDM NG 30/65/1500/80 PPO 19
<b>Network</b>	Liberty	Freedom	Liberty	Freedom
<b>Access</b>	Non-gated	Non-gated	Non-gated	Non-gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$25 per visit \$40 per visit	\$25 per visit \$40 per visit	\$30 per visit \$65 per visit	\$30 per visit \$65 per visit
<b>In-Network Deductible (Single/Family)</b>	\$1,000/\$2,000	\$1,000/\$2,000	\$1,500/\$3,000	\$1,500/\$3,000
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$4,800/\$9,600	\$4,800/\$9,600	\$3,750/\$7,500	\$3,750/\$7,500
<b>In-Network Coinsurance</b>	20%	20%	20%	20%
<b>Outpatient Facility Copayment</b>	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%
<b>Inpatient Facility Copayment</b>	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
<b>Emergency Room</b>	\$100 then deductible then 50%	\$100 then deductible then 50%	\$100 then deductible then 50%	\$100 then deductible then 50%
<b>Out-of-Network Deductible (Single/Family)</b>	\$3,000/\$6,000	\$3,000/\$6,000	\$4,000/\$8,000	\$4,000/\$8,000
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	\$7,500/\$15,000	\$7,500/\$15,000	\$9,000/\$18,000	\$9,000/\$18,000
<b>Out-of-Network Coinsurance</b>	40%	40%	40%	40%
<b>Prescription Drug Coverage</b>	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.

**Additional Benefit Options:**

Domestic Partner

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



## II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

### B. GOLD PLANS (CONTINUED)

Option	<input type="checkbox"/> NJ G LBTY NG 30/50/2000/50 EPO 19	<input type="checkbox"/> NJ G LBTY NG 35/60/1500/70 PPO 19	<input type="checkbox"/> NJ G LBTY NG 30/50/70 PPO 19
<b>Network</b>	Liberty	Liberty	Liberty
<b>Access</b>	Non-gated	Non-gated	Non-gated
<b>Copayment:</b> a. PCP b. Specialist	\$30 per visit \$50 per visit	\$35 per visit \$60 per visit	\$30 per visit \$50 per visit
<b>In-Network Deductible (Single/Family)</b>	\$2,000/\$4,000	\$1,500/\$3,000	N/A
<b>In-Network Maximum Out-of- Pocket (Single/Family)</b>	\$5,750/\$11,500	\$7,150/\$14,300	\$6,000/\$12,000
<b>In-Network Coinsurance</b>	50%	30%	30%
<b>Outpatient Facility Copayment</b>	Deductible and coinsurance	Deductible and coinsurance	30%
<b>Inpatient Facility Copayment</b>	Deductible and coinsurance	Deductible and coinsurance	30%
<b>Emergency Room</b>	\$100 then coinsurance	\$100 then coinsurance	\$100 then coinsurance
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	\$4,500/\$9,000	\$5,000/10,000
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	\$10,000/\$20,000	\$10,000/\$20,000
<b>Out-of-Network Coinsurance</b>	N/A	50%	50%
<b>Prescription Drug Coverage</b>	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..

**Additional Benefit Options:**

Domestic Partner

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

## II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

### C. SILVER PLANS

Option	<input type="checkbox"/> NJ S LBTY NG 30/50/2000/80 EPO HSA 19	<input type="checkbox"/> NJ S LBTY NG 40/75/2500/50 EPO 19	<input type="checkbox"/> NJ S LBTY NG 50/75/2500/70 PPO 19
<b>Network</b>	Liberty	Liberty	Liberty
<b>Access</b>	Non-gated	Non-gated	Non-gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$30 per visit after deductible \$50 per visit after deductible	\$40 per visit \$75 per visit	\$50 per visit \$75 per visit
<b>In-Network Deductible (Single/ Family)</b>	\$2,000/\$4,000	\$2,500/\$5,000	\$2,500/\$5,000
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$6,550/\$13,100	\$7,500/\$15,000	\$7,500/\$15,000
<b>In-Network Coinsurance</b>	20%	50%	30%
<b>Outpatient Facility Copayment</b>	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 – \$250 Hospital Facility – \$500
<b>Inpatient Facility Copayment</b>	Deductible then \$500 per day (\$1,500 max per year)	Deductible and coinsurance	Deductible and coinsurance
<b>Emergency Room</b>	\$100 then deductible and coinsurance	\$100 then deductible and coinsurance	\$100 then deductible then 50%
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A	\$5,000/\$10,000
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A	\$12,500/\$25,000
<b>Out-of-Network Coinsurance</b>	N/A	N/A	50%
<b>Prescription Drug Coverage</b>	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

**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)

### C. SILVER PLANS

Option	<input type="checkbox"/> NJ S FRDM NG 50/75/2500/70 PPO 19	<input type="checkbox"/> NJ S FRDM NG 2500/100 PPO HSA 19	<input type="checkbox"/> NJ S LBTY NG 20/40/2000/60 PPO HSA 19
<b>Network</b>	Freedom	Freedom	Liberty
<b>Access</b>	Non-gated	Non-gated	Non-gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$50 per visit \$75 per visit	Deductible then no charge Deductible then no charge	\$20 per visit after deductible \$40 per visit after deductible
<b>In-Network Deductible (Single/Family)</b>	\$2,500/\$5,000	\$2,500/\$5,000	\$2,000/\$4,000
<b>In-Network Maximum Out-of-Pocket (Single/ Family)</b>	\$7,500/\$15,000	\$6,650/\$13,300	\$6,000/\$12,000
<b>In-Network Coinsurance</b>	30%	N/A	40%
<b>Outpatient Facility Copayment</b>	Freestanding Facility – \$250 Hospital Facility – \$500	Deductible then no charge (Freestanding and Hospital)	Deductible then \$200 (Freestanding and Hospital)
<b>Inpatient Facility Copayment</b>	Deductible and coinsurance	\$500 per day after deductible. \$1500 max per year.	\$400 per day after deductible. \$2000 max per year.
<b>Emergency Room</b>	\$100 then deductible then 50%	\$100 then deductible	\$100 then deductible
<b>Out-of-Network Deductible (Single/Family)</b>	\$5,000/\$10,000	\$5,000/\$10,000	\$4,000/\$8,000
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	\$12,500/\$25,000	\$13,700/\$27,400	\$8,000/\$16,000
<b>Out-of-Network Coinsurance</b>	50%	50%	50%
<b>Prescription Drug Coverage</b>	Tier 1 – \$25 copayment Tier 2 – \$50 copayment Tier 3 – \$75 copayment Mail-Order – 2x copay Deductible – N/A	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.**

\*\*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	<input type="checkbox"/> NJ B LBTY NG 3000/50 EPO HSA 19	<input type="checkbox"/> NJ B LBTY NG 10/70/3000/50 EPO HSA 19
<b>Network</b>	Liberty	Liberty
<b>Access</b>	Non-gated	Non-gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	Deductible then 50% coinsurance	\$10 per visit after deductible \$70 per visit after deductible
<b>In-Network Deductible (Single/Family)</b>	\$3,000/\$6,000	\$3,000/\$6,000
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$6,550/\$13,100	\$6,550/\$13,100
<b>In-Network Coinsurance</b>	50%	50%
<b>Outpatient Facility Copayment</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Inpatient Facility Copayment</b>	Deductible then \$100 per day to \$500 maximum per admit (\$1000 maximum per year)	Deductible then \$50 per day to \$250 maximum per admit (\$500 maximum per year)
<b>Emergency Room</b>	Deductible then \$100 then coinsurance	Deductible then \$100 then coinsurance
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A
<b>Out-of-Network Coinsurance</b>	N/A	N/A
<b>Prescription Drug Coverage</b>	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	<input type="checkbox"/> NJ P GDST NG 10/40/100 EPO 19	<input type="checkbox"/> NJ P GDST NG 10/50/500/90 EPO 19	<input type="checkbox"/> NJ P GDST GT 10/50/250/90 EPO ADV 19	<input type="checkbox"/> NJ G GDST NG 1500/100 EPO HSA 19 19
<b>Network</b>	Garden State	Garden State	Garden State	Garden State
<b>Access</b>	Non-gated	Non-gated	Gated	Non-gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$10 per visit \$40 per visit	\$10 per visit \$50 per visit	\$10 per visit \$50 per visit	Deductible then no charge Deductible then no charge
<b>In-Network Deductible (Single/Family)</b>	N/A	\$500/\$1,000	\$250/\$500	\$1,500/\$3,000
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$2,500/\$5,000	\$4,000/\$8,000	\$3,000/\$6,000	\$4,000/\$8,000
<b>In-Network Coinsurance</b>	N/A	10%	10%	N/A
<b>Outpatient Facility Copayment</b>	Freestanding Facility – \$50 Hospital Facility – \$150	Freestanding Facility – \$150 Hospital Facility – \$300	Freestanding Facility - deductible then 10% Hospital Facility - deductible then 30%	Freestanding Facility – deductible then no charge Hospital Facility – deductible then no charge
<b>Inpatient Facility Copayment</b>	\$400 per admit	\$400 per admit	Deductible then 10%	Deductible then \$500
<b>Emergency Room</b>	\$100	\$100	\$100 then deductible and coinsurance	Deductible then \$100.
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>Out-of-Network Coinsurance</b>	N/A	N/A	N/A	N/A
<b>Prescription Drug Coverage</b>	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	Tier 1 - \$5 copayment Tier 2 - \$30 copayment Tier 3 - \$60 copayment Mail Order - 2x copay Deductible \$150***	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	<input type="checkbox"/> NJ G GDST GT 15/60/1500/80 EPO ADV 19	<input type="checkbox"/> NJ G GDST NG 10/50/1000/90 EPO PA 19	<input type="checkbox"/> NJ G GDST NG 25/50/1250/80 EPO 19	<input type="checkbox"/> NJ G GDST NG 25/50/500/50 EPO 19
<b>Network</b>	Garden State	Garden State	Garden State	Garden State
<b>Access</b>	Gated	Non-gated	Non-gated	Non-gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$15 per visit \$60 per visit	\$10 per visit \$50 per visit after deductible	\$25 per visit \$50 per visit	\$25 per visit \$50 per visit
<b>In-Network Deductible (Single/Family)</b>	\$1,500/\$3,000	\$1,000/\$2,000	\$1,250/\$2,500	\$500/\$1,000
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$6,000/\$12,000	\$4,000/\$8,000	\$4,000/\$8,000	\$4,750/\$9,500
<b>In-Network Coinsurance</b>	20%	10%	20%	50%
<b>Outpatient Facility Copayment</b>	Freestanding Facility – deductible then 20% Hospital Facility – deductible then 40%	Freestanding Facility – deductible then \$75 Hospital Facility – deductible then \$150	Freestanding Facility – \$75 Hospital Facility – \$150	Freestanding Facility – \$125 Hospital Facility – \$250
<b>Inpatient Facility Copayment</b>	20% after deductible	\$500 after deductible	\$500	\$500
<b>Emergency Room</b>	\$100 then deductible and 20% coinsurance	\$100 then deductible and 50% coinsurance	\$100 then deductible and 50% coinsurance	\$100 then deductible and 50% coinsurance
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A	N/A	N/A
<b>Out-of-Network Coinsurance</b>	N/A	N/A	N/A	N/A
<b>Prescription Drug Coverage</b>	Tier 1 – \$5 copayment Tier 2 – \$50 copayment Tier 3 – \$70 copayment Mail-Order – 2x copay Deductible \$150***	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***

## II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

### E. GARDEN STATE PLANS (CONTINUED)

Option	<input type="checkbox"/> NJ G GDST NG 30/60/2000/70 EPO 19	<input type="checkbox"/> NJ S GDST NG 25/50/2000/80 EPO HSA 19	<input type="checkbox"/> NJ S GDST NG 40/75/2500/50 EPO 19
<b>Network</b>	Garden State	Garden State	Garden State
<b>Access</b>	Non-gated	Non-gated	Non-gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$30 per visit \$60 per visit	\$25 per visit after deductible \$50 per visit after deductible	\$40 per visit \$75 per visit
<b>In-Network Deductible (Single/Family)</b>	\$2,000/\$4,000	\$2,000/\$4,000	\$2,500/\$5,000
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$7,000/\$14,000	\$6,550/\$13,100	\$7,500/\$15,000
<b>In-Network Coinsurance</b>	30%	20%	50%
<b>Outpatient Facility Copayment</b>	Deductible then coinsurance (Freestanding and Hospital)	Freestanding Facility – deductible then \$75 Hospital Facility – deductible then \$500	Freestanding Facility – \$250 Hospital Facility – \$500
<b>Inpatient Facility Copayment</b>	\$500	\$500 after deductible	\$500
<b>Emergency Room</b>	\$100 then deductible and coinsurance	\$100 then deductible then 30% coinsurance	\$100 then deductible and coinsurance
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A	N/A
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A	N/A
<b>Out-of-Network Coinsurance</b>	N/A	N/A	N/A
<b>Prescription Drug Coverage</b>	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 – \$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***

## II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

### E. GARDEN STATE PLANS (CONTINUED)

Option	<input type="checkbox"/> NJ S GDST NG 50/75/2500/70 EPO 19	<input type="checkbox"/> NJ S GDST GT 50/75/2500/70 EPO 19
<b>Network</b>	Garden State	Garden State
<b>Access</b>	Non-gated	Gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$50 per visit \$75 per visit	\$50 per visit \$75 per visit
<b>In-Network Deductible (Single/Family)</b>	\$2,500/\$5,000	\$2,500/\$5,000
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$7,500/\$15,000	\$7,500/\$15,000
<b>In-Network Coinsurance</b>	30%	30%
<b>Outpatient Facility Copayment</b>	Freestanding Facility – \$250 Hospital Facility – \$500	Freestanding Facility – \$250 Hospital Facility – \$500
<b>Inpatient Facility Copayment</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Emergency Room</b>	\$100 then deductible and 50% coinsurance	\$100 then deductible and 50% coinsurance
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A
<b>Out-of-Network Coinsurance</b>	N/A	N/A
<b>Prescription Drug Coverage</b>	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	<input type="checkbox"/> NJ S GDST GT 20/70/2500/50 EPO ADV 19	<input type="checkbox"/> NJ S GDST NG 25/70/2500/90 EPO PA 19	<input type="checkbox"/> NJ S GDST NG 2500/60 EPO HSA 19
<b>Network</b>	Garden State	Garden State	Garden State
<b>Access</b>	Gated	Non-gated	Non-gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$20 per visit \$70 per visit	\$25 per visit \$70 per visit after deductible	60% after deductible 60% after deductible
<b>In-Network Deductible (Single/Family)</b>	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$7,500/\$15,000	\$7,500/\$15,000	\$6,650/\$13,300
<b>In-Network Coinsurance</b>	50%	10%	40%
<b>Outpatient Facility Copayment</b>	Freestanding Facility – deductible then 50% Hospital Facility – deductible then 50%	Freestanding Facility – deductible then \$100 Hospital Facility – deductible then \$300	Deductible then coinsurance (Freestanding and Hospital)
<b>Inpatient Facility Copayment</b>	Deductible then 50%	Deductible then \$500 per admit	Deductible then \$500 per admit
<b>Emergency Room</b>	\$100 then deductible and 50% coinsurance	\$100 then deductible and 50% coinsurance	\$100 then deductible and coinsurance
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A	N/A
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A	N/A
<b>Out-of-Network Coinsurance</b>	N/A	N/A	N/A
<b>Prescription Drug Coverage</b>	Tier 1 – \$15 copayment Tier 2 – \$50 copayment Tier 3 – \$80 copayment Mail-Order – 2x copay Deductible \$150***	Tier 1 – \$10 copayment Tier 2 – \$40 copayment Tier 3 – \$70 copayment Mail-Order – 2x copay Deductible***	Tier 1 - 50% Tier 2 - 50% Tier 3 - 50% Mail-Order - 2x copay Deductible**

## II. SPECIFICATIONS FOR COVERAGE (CONTINUED)

### E. GARDEN STATE PLANS (CONTINUED)

Option	<input type="checkbox"/> NJ B GDST NG 10/70/3000/50 EPO HSA 19	<input type="checkbox"/> NJ B GDST NG 3000/50 EPO HSA 19
<b>Network</b>	Garden State	Garden State
<b>Access</b>	Non-gated	Non-gated
<b>Copayment:</b> <b>a. PCP</b> <b>b. Specialist</b>	\$10 per visit after deductible \$70 per visit after deductible	50% after deductible
<b>In-Network Deductible (Single/Family)</b>	\$3,000/\$6,000	\$3,000/\$6,000
<b>In-Network Maximum Out-of-Pocket (Single/Family)</b>	\$6,700/\$13,400	\$6,700/\$13,400
<b>In-Network Coinsurance</b>	50%	50%
<b>Outpatient Facility Copayment</b>	Deductible then 50% coinsurance	Deductible then 50% coinsurance
<b>Inpatient Facility Copayment</b>	Deductible then \$500	Deductible then \$500
<b>Emergency Room</b>	Deductible then \$100 then coinsurance.	Deductible then \$100 then coinsurance.
<b>Out-of-Network Deductible (Single/Family)</b>	N/A	N/A
<b>Out-of-Network Maximum Out-of-Pocket (Single/Family)</b>	N/A	N/A
<b>Out-of-Network Coinsurance</b>	N/A	N/A
<b>Prescription Drug Coverage</b>	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.

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

#### **Additional Benefit Options:**

Domestic Partner

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



## 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