United Healthcare Oxford

New Jersey Application for a Small Employer Health Benefits Policy

Oxford Health Insurance, Inc. (OHI)

Mailing Address: 14 Central Park Drive • Hooksett, NH 03106

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

Fax

Telephone & Facsimile:

Email Address: _____

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

Monthly invoices should be provided ☐ **electronically (through the Group Portal) 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 excluding Spouse ☐ Employees and Dependents including 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 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

Plan Name	☐ NJ P FRDM NG 15/40/100 EPO 24	☐ NJ P FRDM NG 20/40/100 PPO 24	☐ NJ P LBTY NG 15/40/100 EPO 24	☐ NJ P LBTY NG 15/45/100 PPO 24
Network	Freedom	Freedom	Liberty	Liberty
Gatekeeper	N	N	N	N
Copayment				
PCP	$15	$20	$15	$15
Specialist	$40	$40	$40	$45
24/7 Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	N/A	N/A	N/A	N/A
Network Deductible (Family)	N/A	N/A	N/A	N/A
Network Maximum Out of Pocket (Single)	$3,500	$3,500	$3,500	$3,500
Network Maximum Out of Pocket (Family)	$7,000	$7,000	$7,000	$7,000
Network Coinsurance	100%	100%	100%	100%
Outpatient Surgery				
Freestanding	$10	$10	$10	$10
Hospital	$500	$500	$500	$500
Inpatient Facility per Day	$250/day up to $1,250 max	$200/day up to $1,000 max	$300/day up to $1,500 max	$300/day up to $1,500 max
Emergency Room	$100	$100	$100	$100
Out-of-Network Deductible (Single)	N/A	$4,000	N/A	$4,000
Out-of-Network Deductible (Family)	N/A	$8,000	N/A	$8,000
Out-of-Network Maximum Out of Pocket (Single)	N/A	$8,000	N/A	$8,000
Out-of-Network Maximum Out of Pocket (Family)	N/A	$16,000	N/A	$16,000
Out-of-Network Coinsurance	N/A	70%	N/A	70%
Prescription Drug Plans	$5/$25/$50 SpRx: $5/20% up to $150/50% up to $150	$5/$25/$50 SpRx: $5/20% up to $150/50% up to $150	$5/$25/$50 SpRx: $5/20% up to $150/50% up to $500	$5/$25/$50 SpRx: $5/20% up to $150/50% up to $500

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)

A. Platinum Plans (continued)

Plan Name	☐ NJ P MTRO GT 5/75/100 EPO 24	☐ NJ P MTRO NG 10/40/100 EPO 24
Network	Metro	Metro
Gatekeeper	Y	N
Copayment		
PCP	$5	$10
Specialist	$75	$40
24/7 Virtual Visit	100%	100%
Network Deductible (Single)	N/A	N/A
Network Deductible (Family)	N/A	N/A
Network Maximum Out of Pocket (Single)	$3,000	$3,500
Network Maximum Out of Pocket (Family)	$6,000	$7,000
Network Coinsurance	100%	100%
Outpatient Surgery		
Freestanding	$10	$10
Hospital	50%	$500
Inpatient Facility per Day	$500/day up to $2,500 max	$200/day up to $400 max
Emergency Room	50%	$100
Out-of-Network Deductible (Single)	N/A	N/A
Out-of-Network Deductible (Family)	N/A	N/A
Out-of-Network Maximum Out of Pocket (Single)	N/A	N/A
Out-of-Network Maximum Out of Pocket (Family)	N/A	N/A
Out-of-Network Coinsurance	N/A	N/A
Prescription Drug Plans	$100 D T2/3 $5/$25/$60 SpRx: $5/20% up to $150/50% up to $150	$100 D T2/3 $5/$35/$60 SpRx: $5/20% up to $150/50% up to $150

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)

B. Gold Plans

Plan Name	☐ NJ G FRDM NG 50/75/1000/100 EPO 24	☐ NJ G FRDM NG 25/60/1250/80 PPO 24	☐ NJ G FRDM NG 30/75/1500/80 PPO 24	☐ NJ G FRDM GT 50/75/100 EPO ZD 24
Network	Freedom	Freedom	Freedom	Freedom
Gatekeeper	N	N	N	Y
Copayment				
PCP	$50	$25	$30	$50
Specialist	$75	$60	$75	$75
24/7 Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$1,000	$1,250	$1,500	N/A
Network Deductible (Family)	$2,000	$2,500	$3,000	N/A
Network Maximum Out of Pocket (Single)	$6,500	$5,500	$5,000	$7,250
Network Maximum Out of Pocket (Family)	$13,000	$11,000	$10,000	$14,500
Network Coinsurance	100%	80%	80%	100%
Outpatient Surgery				
Freestanding	$100	Ded + $100	$100	$150
Hospital	Ded + 50%	Ded + 50%	Ded + 50%	$500
Inpatient Facility per Day	$500/day up to $2,500 max	Ded + 20%	Ded + 20%	$500/day up to $2,500 max
Emergency Room	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%	$100
Out-of-Network Deductible (Single)	N/A	$4,000	$4,000	N/A
Out-of-Network Deductible (Family)	N/A	$8,000	$8,000	N/A
Out-of-Network Maximum Out of Pocket (Single)	N/A	$8,000	$9,000	N/A
Out-of-Network Maximum Out of Pocket (Family)	N/A	$16,000	$18,000	N/A
Out-of-Network Coinsurance	N/A	60%	60%	N/A
Prescription Drug Plans	$15/$35/$75 SpRx: $15/20% up to $150/50% up to $150	$15/$35/$75 SpRx: $15/20% up to $150/50% up to $150	$15/$35/$75 SpRx: $15/20% up to $150/50% up to $150	$100 D T2/3 $7/$35/$75 SpRx: $7/20% up to $150/50% up to $500

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)

B. Gold Plans (continued)

Plan Name	☐ NJ G LBTY GT 50/75/1000/100 EPO 24	☐ NJ G LBTY NG 50/75/1000/100 EPO 24	☐ NJ G LBTY GT 15/75/1000/50 EPO 24	☐ NJ G LBTY NG 25/50/1250/50 EPO 24
Network	Liberty	Liberty	Liberty	Liberty
Gatekeeper	Y	N	Y	N
Copayment				
PCP	$50	$50	$15	$25
Specialist	$75	$75	$75	$50
24/7 Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$1,000	$1,000	$1,000	$1,250
Network Deductible (Family)	$2,000	$2,000	$2,000	$2,500
Network Maximum Out of Pocket (Single)	$6,500	$6,500	$8,500	$5,500
Network Maximum Out of Pocket (Family)	$13,000	$13,000	$17,000	$11,000
Network Coinsurance	100%	100%	50%	50%
Outpatient Surgery				
Freestanding	$100	$100	$100	$100
Hospital	Ded + 50%	Ded + 50%	Ded + 50%	Ded + 50%
Inpatient Facility per Day	$500/day up to $2,500 max	$500/day up to $2,500 max	Ded + 50%	Ded + 50%
Emergency Room	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%
Out-of-Network Deductible (Single)	N/A	N/A	N/A	N/A
Out-of-Network Deductible (Family)	N/A	N/A	N/A	N/A
Out-of-Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out-of-Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out-of-Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug Plans	$15/$35/$75 SpRx: $15/20% up to $150/50% up to $150	$15/$35/$75 SpRx: $15/20% up to $150/50% up to $150	$100 D T2/3 $5/$35/$75 SpRx: $5/20% up to $150/50% up to $500	$15/$35/$75 SpRx: $15/20% up to $150/50% up to $150

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)

B. Gold Plans (continued)

Plan Name	☐ NJ G LBTY NG 25/60/1500/80 EPO 24	☐ NJ G LBTY NG 30/75/1500/80 EPO 24	☐ NJ G LBTY NG 25/60/1500/70 EPO 24	☐ NJ G LBTY NG 30/65/1500/80 PPO 24
Network	Liberty	Liberty	Liberty	Liberty
Gatekeeper	N	N	N	N
Copayment				
PCP	$25	$30	$25	$30
Specialist	$60	$75	$60	$65
24/7 Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$1,500	$1,500	$1,500	$1,500
Network Deductible (Family)	$3,000	$3,000	$3,000	$3,000
Network Maximum Out of Pocket (Single)	$5,000	$5,500	$5,500	$5,500
Network Maximum Out of Pocket (Family)	$10,000	$11,000	$11,000	$11,000
Network Coinsurance	80%	80%	70%	80%
Outpatient Surgery				
Freestanding	$100	Ded + 20%	Ded + 30%	$100
Hospital	Ded + 50%	Ded + 50%	Ded + 30%	Ded + 50%
Inpatient Facility per Day	Ded + 20%	Ded + 20%	Ded + 30%	Ded + 20%
Emergency Room	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%
Out-of-Network Deductible (Single)	N/A	N/A	N/A	$4,000
Out-of-Network Deductible (Family)	N/A	N/A	N/A	$8,000
Out-of-Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	$9,000
Out-of-Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	$18,000
Out-of-Network Coinsurance	N/A	N/A	N/A	60%
Prescription Drug Plans	$75 D T2/3 $5/$35/$75 SpRx: $5/20% up to $150/50% up to $500	$75 D T2/3 $5/$35/$75 SpRx: $5/20% up to $150/50% up to $500	$100 D T2/3 $5/$35/$75 SpRx: $5/20% up to $150/50% up to $500	$75 D T2/3 $5/$35/$75 SpRx: $5/20% up to $150/50% up to $500

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)

B. Gold Plans (continued)

Plan Name	☐ NJ G LBTY NG 1600/90 EPO HSA PR 24	☐ NJ G LBTY NG 30/50/2000/50 EPO 24	☐ NJ G LBTY NG 35/60/2000/70 PPO 24	☐ NJ G LBTY GT 50/75/100 EPO ZD 24
Network	Liberty	Liberty	Liberty	Liberty
Gatekeeper	N	N	N	Y
Copayment				
PCP	Ded + 10%	$30	$35	$50
Specialist	Ded + 10%	$50	$60	$75
24/7 Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$1,600	$2,000	$2,000	N/A
Network Deductible (Family)	$3,200	$4,000	$4,000	N/A
Network Maximum Out of Pocket (Single)	$5,000	$6,000	$7,500	$7,250
Network Maximum Out of Pocket (Family)	$10,000	$12,000	$15,000	$14,500
Network Coinsurance	90%	50%	70%	100%
Outpatient Surgery				
Freestanding	Ded + 10%	Ded + 50%	Ded + 30%	$150
Hospital	Ded + 10%	Ded + 50%	Ded + 30%	$500
Inpatient Facility per Day	Ded + 10%	Ded + 50%	Ded + 30%	$500/day up to $2,500 max
Emergency Room	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%	$100
Out-of-Network Deductible (Single)	N/A	N/A	$4,500	N/A
Out-of-Network Deductible (Family)	N/A	N/A	$9,000	N/A
Out-of-Network Maximum Out of Pocket (Single)	N/A	N/A	$10,000	N/A
Out-of-Network Maximum Out of Pocket (Family)	N/A	N/A	$20,000	N/A
Out-of-Network Coinsurance	N/A	N/A	50%	N/A
Prescription Drug Plans	Medical Deductible $5/$50/50% up to $150 SpRx: $5/20% up to $150/50% up to $150	$75 D T2/3 $5/$35/$75 SpRx: $5/20% up to $150/50% up to $500	$75 D T2/3 $5/$35/$75 SpRx: $5/20% up to $150/50% up to $500	$100 D T2/3 $7/$35/$75 SpRx: $7/20% up to $150/50% up to $500

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)

B. Gold Plans (continued)

Plan Name	☐ NJ G MTRO GT 25/75/1250/80 EPO 24	☐ NJ G MTRO NG 25/50/1250/50 EPO 24	☐ NJ G MTRO NG 25/60/1500/80 EPO 24	☐ NJ G MTRO NG 30/60/1800/100 EPO 24
Network	Metro	Metro	Metro	Metro
Gatekeeper	Y	N	N	N
Copayment				
PCP	$25	$25	$25	$30
Specialist	$75	$50	$60	$60
24/7 Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$1,250	$1,250	$1,500	$1,800
Network Deductible (Family)	$2,500	$2,500	$3,000	$3,600
Network Maximum Out of Pocket (Single)	$6,000	$5,500	$5,000	$9,100
Network Maximum Out of Pocket (Family)	$12,000	$11,000	$10,000	$18,200
Network Coinsurance	80%	50%	80%	100%
Outpatient Surgery				
Freestanding	Ded + $200	$100	$100	Ded + $50
Hospital	Ded + 50%	Ded + 50%	Ded + 50%	Ded + 50%
Inpatient Facility per Day	Ded + 20%	Ded + 50%	Ded + 20%	Ded + $500/day up to $2,500 max
Emergency Room	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%	Ded + $100
Out-of-Network Deductible (Single)	N/A	N/A	N/A	N/A
Out-of-Network Deductible (Family)	N/A	N/A	N/A	N/A
Out-of-Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out-of-Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out-of-Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug Plans	$100 D T2/3 $5/$25/$60 SpRx: $5/20% up to $150/50% up to $150	$100 D T2/3 $10/$40/50% SpRx: $10/20% up to $150/50% to $500	$100 D T2/3 $10/$40/50% SpRx: $10/20% up to $150/50% to $500	$15/$50/50% up to $150 SpRx: $15/20% up to $150/50% up to $150

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)

B. Gold Plans (continued)

Plan Name	☐ NJ G MTRO GT 30/60/1800/100 EPO 24	☐ NJ G MTRO NG 2000/100 EPO HSA 24	☐ NJ G MTRO GT 5/75/2000/50 EPO 24
Network	Metro	Metro	Metro
Gatekeeper	Y	N	Y
Copayment			
PCP	$30	$0 after Ded	$5
Specialist	$60	$0 after Ded	$75
24/7 Virtual Visit	100%	100%	100%
Network Deductible (Single)	$1,800	$2,000	$2,000
Network Deductible (Family)	$3,600	$4,000	$4,000
Network Maximum Out of Pocket (Single)	$9,100	$6,000	$7,500
Network Maximum Out of Pocket (Family)	$18,200	$12,000	$15,000
Network Coinsurance	100%	100%	50%
Outpatient Surgery			
Freestanding	Ded + $50	$0 after Ded	$500
Hospital	Ded + 50%	$0 after Ded	Ded + $500
Inpatient Facility per Day	Ded + $500/day up to $2,500 max	$0 after Ded	Ded + 50%
Emergency Room	Ded + $100	$100 + Ded + 50%	Ded + 50%
Out-of-Network Deductible (Single)	N/A	N/A	N/A
Out-of-Network Deductible (Family)	N/A	N/A	N/A
Out-of-Network Maximum Out of Pocket (Single)	N/A	N/A	N/A
Out-of-Network Maximum Out of Pocket (Family)	N/A	N/A	N/A
Out-of-Network Coinsurance	N/A	N/A	N/A
Prescription Drug Plans	$15/$50/50% up to $150 SpRx: $15/20% up to $150/50% up to $150	Medical Deductible $10/$40/50% SpRx: $10/20% up to $150/50% up to $500	$100 D T2/3 $5/$25/$60 SpRx: $5/20% up to $150/50% up to $150

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)

C. Silver Plans

Plan Name	☐ NJ S FRDM NG 2500/75 PPO HSA 24	☐ NJ S FRDM NG 50/75/2500/50 PPO 24	☐ NJ S LBTY NG 2500/60 EPO HSA PR 24	☐ NJ S LBTY NG 30/50/2500/60 EPO HSA 24
Network	Freedom	Freedom	Liberty	Liberty
Gatekeeper	N	N	N	N
Copayment				
PCP	Ded + 25%	$50	Ded + 40%	Ded + $30
Specialist	Ded + 25%	$75	Ded + 40%	Ded + $50
24/7 Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$2,500	$2,500	$2,500	$2,500
Network Deductible (Family)	$5,000	$5,000	$5,000	$5,000
Network Maximum Out of Pocket (Single)	$8,000	$9,450	$7,350	$7,350
Network Maximum Out of Pocket (Family)	$16,000	$18,900	$14,700	$14,700
Network Coinsurance	75%	50%	60%	60%
Outpatient Surgery				
Freestanding	Ded + 25%	Ded + $500	Ded + 40%	Ded + $250
Hospital	Ded + 50%	Ded + 50%	Ded + 40%	Ded + 50%
Inpatient Facility per Day	Ded + $500/day up to $2,500 max	Ded + 50%	Ded + 40%	Ded + 40%
Emergency Room	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%
Out-of-Network Deductible (Single)	$5,000	$5,000	N/A	N/A
Out-of-Network Deductible (Family)	$10,000	$10,000	N/A	N/A
Out-of-Network Maximum Out of Pocket (Single)	$13,700	$12,500	N/A	N/A
Out-of-Network Maximum Out of Pocket (Family)	$27,400	$25,000	N/A	N/A
Out-of-Network Coinsurance	50%	50%	N/A	N/A
Prescription Drug Plans	Medical Deductible $5/$50/50% up to $150 SpRx: $5/20% up to $150/50% up to $150	$250 D T2/3 $25/$50/50% SpRx: $25/20% up to $150/50% up to $500	Medical Deductible $5/$50/50% up to $150 SpRx: $5/20% up to $150/50% up to $150	Medical Deductible $5/$50/50% up to $150 SpRx: $5/20% up to $150/50% up to $150

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)

C. Silver Plans (continued)

Plan Name	☐ NJ S LBTY GT 30/75/2500/50 EPO 24	☐ NJ S LBTY NG 50/75/2500/50 EPO 24	☐ NJ S LBTY NG 20/40/2500/60 PPO HSA 24	☐ NJ S LBTY NG 50/75/2500/50 PPO 24
Network	Liberty	Liberty	Liberty	Liberty
Gatekeeper	Y	N	N	N
Copayment				
PCP	Ded + $30	$50	Ded + $20	$50
Specialist	Ded + $75	$75	Ded + $40	$75
24/7 Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$2,500	$2,500	$2,500	$2,500
Network Deductible (Family)	$5,000	$5,000	$5,000	$5,000
Network Maximum Out of Pocket (Single)	$8,700	$9,450	$7,350	$9,450
Network Maximum Out of Pocket (Family)	$17,400	$18,900	$14,700	$18,900
Network Coinsurance	50%	50%	60%	50%
Outpatient Surgery				
Freestanding	Ded + $100	Ded + $500	Ded + $250	Ded + $500
Hospital	Ded + 50%	Ded + 50%	Ded + 50%	Ded + 50%
Inpatient Facility per Day	Ded + 50%	Ded + 50%	Ded + 60%	Ded + 50%
Emergency Room	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%
Out-of-Network Deductible (Single)	N/A	N/A	$5,000	$5,000
Out-of-Network Deductible (Family)	N/A	N/A	$10,000	$10,000
Out-of-Network Maximum Out of Pocket (Single)	N/A	N/A	$10,000	$12,500
Out-of-Network Maximum Out of Pocket (Family)	N/A	N/A	$20,000	$25,000
Out-of-Network Coinsurance	N/A	N/A	50%	50%
Prescription Drug Plans	$250 D T2/3 $5/$50/50% SpRx: $5/20% up to $150/50% up to $500	$250 D T2/3 $25/$50/50% SpRx: $25/20% up to $150/50% up to $500	Medical Deductible $5/$50/50% up to $150 SpRx: $5/20% up to $150/50% up to $150	$250 D T2/3 $25/$50/50% SpRx: $25/20% up to $150/50% up to $500

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)

C. Silver Plans (continued)

Plan Name	☐ NJ S MTRO NG 25/50/2500/80 EPO HSA 24	☐ NJ S MTRO GT 35/50/2500/70 EPO HSA 24	☐ NJ S MTRO GT 30/60/2500/60 EPO 24	☐ NJ S MTRO NG 50/75/2500/50 EPO 24
Network	Metro	Metro	Metro	Metro
Gatekeeper	N	Y	Y	N
Copayment				
PCP	Ded + $25	Ded + $35	Ded + $30	$50
Specialist	Ded + $50	Ded + $50	Ded + $60	$75
24/7 Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$2,500	$2,500	$2,500	$2,500
Network Deductible (Family)	$5,000	$5,000	$5,000	$5,000
Network Maximum Out of Pocket (Single)	$7,350	$7,350	$9,200	$9,450
Network Maximum Out of Pocket (Family)	$14,700	$14,700	$18,400	$18,900
Network Coinsurance	80%	70%	60%	50%
Outpatient Surgery				
Freestanding	Ded + $250	Ded + $300	Ded + $250	Ded + $500
Hospital	Ded + $500	Ded + 30%	Ded + 50%	Ded + 50%
Inpatient Facility per Day	Ded + $500 Admit	Ded + 30%	Ded + $500/day up to $2,500 max	Ded + 50%
Emergency Room	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%
Out-of-Network Deductible (Single)	N/A	N/A	N/A	N/A
Out-of-Network Deductible (Family)	N/A	N/A	N/A	N/A
Out-of-Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out-of-Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out-of-Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug Plans	Medical Deductible $5/$50/50% SpRx: $5/20% up to $150/50% up to $500	Medical Deductible $5/$50/50% SpRx: $5/20% up to $150/50% up to $500	$25/50% up to $150/50% SpRx: $25/50% up to $150/50% up to $150	$250 D T2/3 $15/$50/50% SpRx: $15/20% up to $150/50% up to $500

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)

D. Bronze Plans

Plan Name	☐ NJ B LBTY NG 5900/50 EPO HSA 24	☐ NJ B LBTY NG 10/70/6000/50 EPO HSA 24	☐ NJ B MTRO NG 5900/50 EPO HSA 24	☐ NJ B MTRO NG 10/70/6000/50 EPO HSA 24
Network	Liberty	Liberty	Metro	Metro
Gatekeeper	N	N	N	N
Copayment				
PCP	Ded + 50%	Ded + $10	Ded + 50%	Ded + $10
Specialist	Ded + 50%	Ded + $70	Ded + 50%	Ded + $70
24/7 Virtual Visit	100%	100%	100%	100%
Network Deductible (Single)	$5,900	$6,000	$5,900	$6,000
Network Deductible (Family)	$11,800	$12,000	$11,800	$12,000
Network Maximum Out of Pocket (Single)	$7,250	$7,250	$7,250	$7,250
Network Maximum Out of Pocket (Family)	$14,500	$14,500	$14,500	$14,500
Network Coinsurance	50%	50%	50%	50%
Outpatient Surgery				
Freestanding	Ded + 50%	Ded + 50%	Ded + 50%	Ded + 50%
Hospital	Ded + 50%	Ded + 50%	Ded + 50%	Ded + 50%
Inpatient Facility per Day	Ded + $100/day up to $500 max	Ded + $50/day up to $250 max	Ded + $100/day up to $500 max	Ded + $50/day up to $250 max
Emergency Room	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%	$100 + Ded + 50%
Out-of-Network Deductible (Single)	N/A	N/A	N/A	N/A
Out-of-Network Deductible (Family)	N/A	N/A	N/A	N/A
Out-of-Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out-of-Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out-of-Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug Plans	Medical Deductible 50% up to $150 SpRx: 50% up to $150	Medical Deductible 50% up to $150 SpRx: 50% up to $150	Medical Deductible 50% SpRx: 50%	Medical Deductible 50% up to $250 SpRx: 50% up to $250

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)

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 the 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.