

## New York Small Group (2-50) Application – OHI

Oxford Health Insurance Inc. • www.oxfordhealth.com

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

Freedom Plan® Metro<sup>SM</sup>  
 Liberty Plan<sup>SM</sup> Metro  
 Freedom Plan® Metro Access<sup>SM</sup>  
 Liberty Plan<sup>SM</sup> Metro Access  
 Oxford Exclusive Plan<sup>SM</sup> Metro  
 Oxford Ease<sup>SM</sup>

Freedom Plan® Direct<sup>SM</sup>  
 Liberty Plan<sup>SM</sup> Direct  
 Oxford MyPlan<sup>SM</sup>  
 Oxford® HSA Exclusive<sup>SM</sup>  
 Oxford® HSA Direct<sup>SM</sup>  
 Primary Advantage

### I. GENERAL INFORMATION

**1. Full Legal Name of Group:** VERATEX

**2. Primary Address of Group:** 254 FITH AVENUE

(Street Address)  
 City, State, ZIP Code) NEW YORK NY 10001

**No P.O. Box**

**3. Plan Administrator/Contact:**

a. Name Wei Chang

b. Title Benefit Administrator

c. Address 254 FITH AVENUE  
 (If different from primary)  
 City, State, ZIP code NEW YORK, NY 10001

d. Phone Number 212-683-9300 Ext.

e. Fax Number 212-889-5578

f. Email Address

g. Add'l Contact & Number

**4. Name and title of person to receive billing statements:**

a. Name Wei Chang

b. Title

c. Address 254 FITH AVENUE  
 (If different from primary)  
 City, State, ZIP code NEW YORK, NY 10001

d. Phone Number 212 6839300 Ext.

e. Fax Number 212 8895578

**5. Full legal name of each subsidiary and/or affiliated company whose employees are to be covered (if applicable):**

**6. Nature of Business:**

**7. SIC Code:**

**8. Tax Identification Number:** 132804148

OHIN NY GA 513

## II. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate of Coverage. To be eligible for small group coverage, you must be located in a county where we offer this Oxford product and have at least 2 but not more than 50 eligible employees.

1. Effective date: We request that this coverage be effective 12/15/2013.
2. Anniversary date: The anniversary date is the first day of the calendar month that is closest to the effective date.
3. Open enrollment period: The open enrollment period is the month prior to your anniversary date. The open enrollment effective date is the first of the month following the period.
4. How many total employees does this group have? 4  
Total employees means the average number of employees, including seasonal and/or part time employees, during the prior calendar year.
5. How many eligible employees does this group have? 4  
Eligible employees: Active permanent employees of the employer and of all subsidiaries or affiliates of a corporate employer who work **20 or more** hours per week and are eligible for health benefits through the employer's group health plan. Eligible employees do not include:
  - any person who performs services for the company who is reported on an IRS 1099 form (such a person is not an employee and is not eligible for coverage) or
  - any former employee who is covered through retiree benefits, COBRA or state continuation.An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours and occupational duties. Employees who work less than 20 hours per week are not eligible employees and may not enroll in any Oxford products. If coverage is limited to specific class(es) of employees, the classes must be specified in response to question 13 below.
6. Total number of employees being offered coverage through this product: 4  
Of the eligible employees who work 20 or more hours per week, please list all employees who will be offered coverage under this policy. If coverage is limited to specific class(es) of employees, the classes must be specified in response to question 13 below.  
Groups seeking to purchase insurance, rather than HMO coverage, also must meet the minimum participation requirements for coverage. Please see our underwriting guidelines for details on our minimum participation requirements.
7. If the employer offers retiree coverage, how many eligible retired former employees does this group have? 0  
Integration with Medicare benefits: Health benefits covered by Medicare Part A and B are carved out for retired employees aged 65 or over and their dependents aged 65 or over, if the group offers retiree coverage.
8. Total number of employees and former employees enrolling: 2  
Enrolling means the total number of eligible employees, COBRA or state continuation enrollees, and retired employees (if applicable) accepting coverage with any Oxford product.
  - a. of those former employees enrolling, how many are retired? 0
  - b. of those former employees enrolling, how many are enrolling through COBRA or state continuation? 0
9. Total number of employees waiving coverage for the following reasons:
  - a. A spouse's health benefit plan: 2
  - b. Medicare: 0
  - c. Medicaid: 0
  - d. Veteran's coverage: 0
  - e. All other waivers (include number of eligible employees enrolling in other employer-sponsored HMO coverage): 0
10. Total number of valid waivers (a - d): 2
11. Is the Employer offering other group health insurance coverage to employees who are eligible for coverage in an Oxford product? (check no if group only offers other HMO coverage) YES  NO

Please list other current or past group health or HMO coverage offered by Employer in the last three years:

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

## II. ADMINISTRATIVE INFORMATION (CONTINUED)

12. Is your group subject to COBRA (20 or more total employees during at least 50% of the working days in the previous calendar year)?  
\_\_\_\_ YES  NO

13. Eligible employee class(es), Waiting period and Termination:

If coverage is being limited to particular class(es) of employees, please specify class definition(s) below. An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours, and occupational duties. Although an Employer may establish a class of employees who work less than 20 hours per week, Oxford products are not available to employees who work less than 20 hours per week. Oxford must be the sole carrier for all eligible employees who work in New York state as well as any other eligible employees located outside the state of New York who are eligible for coverage under a New York group health benefits plan.

If classes and waiting periods are not specified below, all eligible employees who work 20 or more hours per week will be eligible for group health benefits under an Oxford policy without a waiting period.

Eligibility and Termination: The employee will become eligible on the latter of the effective date of this plan or the date selected below (check appropriate date).

### CLASS I

**Definition of Class I :** All Eligible Employees

i) **Eligibility/Termination**

Date on which the employee completes 30 days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

ii) **Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

iii) **Waiting Period for Rehires**

Waiting Period waived for Rehires?  Yes  No  
If yes, waived if rehired within \_\_\_\_\_ months.

### CLASS II

**Definition of Class II**

i) **Eligibility/Termination**

Date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be the date of termination of employment.

ii) **Eligibility/Termination**

On the first day of the calendar month coinciding with or next following the date on which the employee completes \_\_\_\_\_ days/months (circle one) of continuous service.

Termination will be on the last day of the calendar month.

iii) **Waiting Period for Rehires**

Waiting Period waived for Rehires?  Yes  No  
If yes, waived if rehired within \_\_\_\_\_ months.

### III. PRODUCT AND PLAN DESIGNS

#### A. Oxford Plan Metro (Referrals are required for these plan designs.)

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

Please Select Network:  Freedom  Liberty

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3
<b>Copayment:</b> a. PCP b. Specialist	\$15 per visit \$25 per visit	\$25 per visit \$40 per visit	\$50 per visit \$75 per visit
<b>Inpatient/Outpatient Facility Copayment</b>	\$250 per day up to five days Inpatient (\$1,250 max. copayment per year) / \$250 Outpatient	\$500 per day up to five days Inpatient (\$2,500 max. copayment per year) / \$500 Outpatient	\$750 per day up to five days Inpatient (\$3,750 max. copayment per year) / \$500 Outpatient
<b>Emergency Room Copayment</b>	\$200	\$200	\$200
<b>Out-of-Network Deductible</b>	\$2,000 Single \$6,000 Family	\$2,000 Single \$6,000 Family	\$3,000 Single \$9,000 Family
<b>Out-of-Network Coinsurance</b>	70% to \$10,000	70% to \$10,000	70% to \$20,000
<b>Out-of-Network Reimbursement</b>	140% of Medicare rate <sup>1</sup>	140% of Medicare rate <sup>1</sup>	140% of Medicare rate <sup>1</sup>

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

**Additional Benefit Options:**  Vision  Dental Enhanced  Dental Premium  Other: \_\_\_\_\_ Subject to Home Office Approval

Mandated Offering – Dependent Age Extension to 29  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances  
 Unlimited Mental Health \*\*\*

\*\*\*Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

**Please select optional prescription drug coverage:**

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$30 copayment	\$60 copayment	2.5x copayment	<input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2.5x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

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

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

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

<sup>1</sup> When a Medicare rate is not available, reimbursement is based upon ceratin gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

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

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

Please Select Network:  Freedom  Liberty

Options	<input type="checkbox"/> Metro Plan Access Option 1	<input type="checkbox"/> Metro Plan Access Option 2	<input type="checkbox"/> Metro Plan Access Option 3
Office visit Copayment	\$20 PCP/\$30 specialist	\$30 PCP/\$50 specialist	\$50 PCP/\$75 specialist
Hospital Copayment	\$500 per admission	\$500 per admission	\$750 per admission
Outpatient/Hospital Ambulatory Surgery	\$250 copayment	\$500 copayment	\$500 copayment
Out-of-Network Deductible – Single/Family	\$2,000/\$6,000	\$3,000/\$9,000	\$3,000/\$9,000
Out-of-Network Coinsurance – Single/Family	70% to \$10,000/\$30,000	70% to \$10,000/\$30,000	70% to \$20,000/\$60,000
Out-of-Network Reimbursement	140% of Medicare rate <sup>1</sup>	140% of Medicare rate <sup>1</sup>	140% of Medicare rate <sup>1</sup>

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

**Additional Benefit Options:**  Vision  Dental Enhanced  Dental Premium  
 Mandated Offering – Dependent Age Extension to 29  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances  
 Unlimited Mental Health\*\*\*  
 Other: \_\_\_\_\_

Subject to Home Office Approval

\*\*\*Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

**Please select optional prescription drug coverage:**

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$30 copayment	\$60 copayment	2.5x copayment	<input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2.5x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

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

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

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

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

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

Please Select Network:  Freedom  Liberty

In-Network Only

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6
<b>Copayment:</b> a. PCP b. Specialist	\$15 per visit \$30 per visit	\$25 per visit \$50 per visit	\$15 per visit \$30 per visit	\$25 per visit \$50 per visit	\$20 per visit \$40 per visit	\$50 per visit \$75 per visit
<b>Single Deductible</b>	none	none	\$1,000	\$2,000	N/A	\$2,500
<b>Family Deductible</b>	none	none	\$2,500	\$5,000	N/A	\$6,250
<b>Coinsurance</b>	none	none	80% to \$10,000/\$25,000	90% to \$10,000/\$25,000	N/A	80% to \$20,000/\$50,000
<b>Outpatient Facility Copayment</b>	\$150 per incident	\$300 per incident	Deductible & Coinsurance	Deductible & Coinsurance	\$200 per incident	Deductible & Coinsurance
<b>Inpatient Facility Copayment</b>	\$150 per day to five days maximum per year	\$300 per day to five days maximum per year	Deductible & Coinsurance	Deductible & Coinsurance	\$200 per day to five days maximum per year	Deductible & Coinsurance
<b>Emergency Room</b>	\$200	\$200	\$200	\$200	\$200	\$200

Deductibles and out-of-pocket accumulation periods are on a  calendar year  contract year basis (plans 3, 4 and 6 only).

**Additional Benefit Options:**  Vision  Dental Enhanced  Dental Premium  
 Mandated Offering Dependent Age Extension to 29  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances  
 Unlimited Mental Health\*\*\*  
 Other: \_\_\_\_\_

Subject to Home Office Approval

\*\*\*Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$30 copayment	\$60 copayment	2.5x copayment	<input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2.5x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Option 3	\$15 copayment	\$35 copayment	\$75 copayment	2.5x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

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

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

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

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

Please Select Network:  Freedom  Liberty

In-Network Only

Option	<input type="checkbox"/> Plan 1
<b>Copayment:</b> a. PCP b. Specialist	\$50 per visit \$50 per visit
<b>Single Deductible</b>	N/A
<b>Family Deductible</b>	N/A
<b>Coinsurance</b>	N/A
<b>Outpatient Facility Copayment</b>	\$500 per incident
<b>Inpatient Facility Copayment</b>	\$500 per day, up to a maximum of \$2,500 per calendar year
<b>Emergency Room</b>	\$200

**Additional Benefit Options:**  Vision  Dental Enhanced  Dental Premium  
 Mandated Offering – Dependent Age Extension to 29  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances  
 Unlimited Mental Health\*\*\*  
 Other: \_\_\_\_\_

Subject to Home Office Approval

\*\*\*Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

#### Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$15 copayment	\$35 copayment	\$75 copayment	2.5x copayment	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

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

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

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

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

Please Select Network:  Freedom  Liberty

In-Network/Out-of-Network

Options	<input checked="" type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4
<b>Copayment</b>	\$25 PCP / \$40 Specialist	\$25 PCP / \$40 Specialist	\$30 PCP / \$50 Specialist	\$50 PCP / \$75 Specialist
<b>Single Deductible</b>	\$500/\$1,000	\$1,000/\$2,000	\$2,000/\$2,000	\$2,500/\$6,000
<b>Family Deductible</b>	\$1,250/\$2,500	\$2,500/\$5,000	\$5,000/\$5,000	\$6,250/\$15,000
<b>Coinsurance</b>	80%/60%	80%/60%	80%/60%	80%/60%
<b>Out-of-Network Reimbursement</b>	140% of Medicare rate <sup>1</sup>	140% of Medicare rate <sup>1</sup>	140% of Medicare rate <sup>1</sup>	140% of Medicare rate <sup>1</sup>
<b>Single Maximum Out-of-Pocket</b>	\$2,500/\$5,000	\$3,000/\$6,000	\$4,000/\$6,000	\$6,500/\$18,000
<b>Family Maximum Out-of-Pocket</b>	\$6,250/\$12,500	\$7,500/\$15,000	\$10,000/\$15,000	\$16,250/\$45,000

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

**Additional Benefit Options:**  Vision  Dental Enhanced  Dental Premium  
 Mandatory Offering – Dependent Age Extension to 29  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances  
 Unlimited Mental Health\*\*\*  
 Other: \_\_\_\_\_

Subject to Home Office Approval

\*\*\*Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Please select optional prescription drug coverage:

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input checked="" type="checkbox"/> Option 1	\$10 copayment	\$30 copayment	\$60 copayment	2.5x copayment	<input checked="" type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2.5x copayment or 50%	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$250
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

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

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

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

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

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

Please Select Network:  Freedom  Liberty

In-Network/Out-of-Network

Please select a plan type:

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2
<b>Copayment</b>	N/A	N/A
<b>Single Deductible</b>	\$1,000/\$2,000	\$2,000/\$2,000
<b>Family Deductible</b>	\$2,500/\$5,000	\$5,000/\$5,000
<b>Coinsurance</b>	80%/60%	90%/70%
<b>Out-of-Network Reimbursement</b>	140% of Medicare rate <sup>1</sup>	140% of Medicare rate <sup>1</sup>
<b>Single Maximum Out-of-Pocket</b>	\$3,000/\$6,000	\$3,000/\$5,000
<b>Family Maximum Out-of-Pocket</b>	\$7,500/\$15,000	\$7,500/\$12,500

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

Please select optional prescription drug coverage:

**Additional Benefit Options:**  Vision  Dental Enhanced  Dental Premium  
 Mandated Offering – Dependent Age Extension to 29  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances  
 Unlimited Mental Health\*\*\*

\*\*\*Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

Options	Tier 1	Tier 2	Tier 3	Mail-Order	Deductible** (Please select one)
<input type="checkbox"/> Option 1	\$10 copayment	\$30 copayment	\$60 copayment	2.5x copayment	\$100 (Required)
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2.5x copayment or 50%	\$50 (Required)
<input type="checkbox"/> Waived Coverage	N/A	N/A	N/A	N/A	N/A

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

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

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### G. Oxford HSA Exclusive (No referrals are required for these plan designs.)

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

Please Select Network:  Freedom  Liberty

In-Network Only

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6	<input type="checkbox"/> Plan 7
<b>In-Network Cost Share:</b>							
<b>a. PCP</b>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then \$20	Deductible then \$25	Deductible then \$30
<b>b. Specialist</b>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then \$40	Deductible then \$50	Deductible then \$50
<b>Single Deductible**</b>	\$1,250	\$2,000	\$2,850	\$5,000	\$1,250	\$2,000	\$2,850
<b>Family Deductible**</b>	\$2,500	\$4,000	\$5,700	\$10,000	\$2,500	\$4,000	\$5,700
<b>Coinurance</b>	100%	100%	100%	100%	100%	100%	100%
<b>In-Network Outpatient Facility Copayment</b>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then \$200 Copayment	Deductible then \$250 Copayment	Deductible then \$300 Copayment
<b>In-Network Inpatient Facility Copayment</b>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then \$200 per day to \$1,000 max. per year	Deductible then \$250 per day to \$1,250 max. per year	Deductible then \$300 per day to \$1,500 max. per year
<b>Emergency Room</b>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then \$200	Deductible then \$200	Deductible then \$200
<b>Single Maximum Out-of-Pocket</b>	\$5,000	\$5,000	\$5,000	\$5,950	\$5,000	\$5,500	\$6,050
<b>Family Maximum Out-of-Pocket</b>	\$10,000	\$10,000	\$10,000	\$11,900	\$10,000	\$11,000	\$12,100

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

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

Options	Tier 1	Tier 2	Tier 3	Mail-Order
<input type="checkbox"/> Option 1	\$10 copayment	\$30 copayment	\$60 copayment	2.5x copayment
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2.5x copayment or 50%
<input type="checkbox"/> Option 3 (available with medical plans 5, 6 & 7 only)	\$15 copayment	\$35 copayment	\$75 copayment	2.5x copayment

\*\*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 or copayment, and prescription drug copayment will apply based on the option selected at plan inception. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket have been met. Out-of-network benefits are accumulated separately.

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

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

**Additional Benefit Options:**  Vision

- Dental Enhanced
- Dental Premium
- Mandated Offering – Dependent Age Extension to 29
- Domestic Partner
- Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
- Unlimited Mental Health\*\*\*
- Other: \_\_\_\_\_

Subject to Home Office Approval

\*\*\*Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

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

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

Please Select Network:  Freedom  Liberty

In-Network/Out-of-Network

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6
<b>In-Network Cost Share:</b>						
<b>a. PCP</b>	Deductible & Coinsurance					
<b>b. Specialist</b>	Deductible & Coinsurance					
<b>Single Deductible**</b>	\$1,250/\$2,000	\$2,000/\$2,000	\$2,850/\$2,850	\$1,250/\$2,000	\$2,000/\$2,000	\$2,850/\$2,850
<b>Family Deductible**</b>	\$2,500/\$4,000	\$4,000/\$4,000	\$5,700/\$5,700	\$2,500/\$4,000	\$4,000/\$4,000	\$5,700/\$5,700
<b>Coinurance</b>	80%/60%	90%/70%	90%/70%	100%/70%	100%/70%	100%/70%
<b>In-Network Outpatient Facility Copayment</b>	Deductible & Coinsurance					
<b>In-Network Inpatient Facility Copayment</b>	Deductible & Coinsurance					
<b>Emergency Room</b>	Deductible & Coinsurance					
<b>Single Maximum Out-of-Pocket</b>	\$3,250/\$6,000	\$3,000/\$5,000	\$3,850/\$5,850	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000
<b>Family Maximum Out-of-Pocket</b>	\$6,500/\$12,000	\$6,000/\$10,000	\$7,700/\$11,700	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000

Options	<input type="checkbox"/> Plan 7	<input type="checkbox"/> Plan 8	<input type="checkbox"/> Plan 9
<b>In-Network Cost Share:</b>			
<b>a. PCP</b>	Deductible then \$20	Deductible then \$25	Deductible then \$30
<b>b. Specialist</b>	Deductible then \$40	Deductible then \$50	Deductible then \$50
<b>Single Deductible**</b>	\$1,250/\$2,500	\$2,000/\$4,000	\$2,850/\$5,700
<b>Family Deductible**</b>	\$2,500/\$5,000	\$4,000/\$8,000	\$5,700/\$11,400
<b>Coinurance</b>	100%/70%	100%/70%	100%/70%
<b>In-Network Outpatient Facility Copayment</b>	Deductible then \$200	Deductible then \$250	Deductible then \$300
<b>In-Network Inpatient Facility Copayment</b>	Deductible then \$200 per day to \$1,000 max. per year	Deductible then \$250 per day to \$1,250 max. per year	Deductible then \$300 per day to \$1,500 max. per year
<b>Emergency Room</b>	Deductible then \$200	Deductible then \$200	Deductible then \$200
<b>Single Maximum Out-of-Pocket</b>	\$5,000/\$10,000	\$5,500/\$10,000	\$6,050/\$10,000
<b>Family Maximum Out-of-Pocket</b>	\$10,000/\$20,000	\$11,000/\$20,000	\$12,100/\$20,000

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

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

**Additional Benefit Options:**

- Vision
- Dental Enhanced
- Dental Premium
- Mandated Offering – Dependent Age Extension to 29
- Domestic Partner
- Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances
- Unlimited Mental Health\*\*\*
- Other: \_\_\_\_\_

Subject to Home Office Approval

\*\*\*Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year.

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

Options	Tier 1	Tier 2	Tier 3	Mail-Order
<input type="checkbox"/> Option 1	\$10 copayment	\$30 copayment	\$60 copayment	2.5x copayment
<input type="checkbox"/> Option 2	\$15 copayment	50%	50%	2.5x copayment or 50%
<input type="checkbox"/> Option 3 (available with medical plans 7, 8 & 9 only)	\$15 copayment	\$35 copayment	\$75 copayment	2.5x copayment

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

\*\*NOTE: All in-network medical and pharmacy services are subject to the in-network deductible. Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copayment will apply based on the option selected at plan inception. Out-of-network benefits are accumulated separately. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket have been met.

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?  Yes  No

### III. PRODUCT AND PLAN DESIGNS (CONTINUED)

#### I. Oxford – Primary Advantage (Non-gated – No referrals required)

Note: The below is not an all inclusive list of plan benefits.

Option	<input type="checkbox"/> Plan 1
<b>Cost Share:</b> a. PCP b. Specialist	\$25 copayment Deductible then \$50 copayment
<b>Single Deductible</b>	\$1,500
<b>Family Deductible</b>	\$3,750
<b>Coinsurance</b>	N/A
<b>Outpatient Facility Copayment</b>	Deductible then \$150 copayment
<b>Inpatient Facility Copayment</b>	Deductible then \$250 copayment up to 5 days per admission
<b>Emergency Room</b>	Deductible then \$250 copayment
<b>Pharmacy**</b>	\$15/Deductible then 50% up to \$250 per prescription

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

**Additional Benefit Options:**  Vision       Dental Enhanced       Dental Premium  
 Mandated Offering - Dependent Age Extension to 29  
 Domestic Partner  
 Coverage for Biologically Based Mental Illness and Children with Serious Emotional Disturbances  
 Unlimited Mental Health\*\*\*  
 Other: \_\_\_\_\_

Subject to Home Office Approval

\*\*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 or copayment, and prescription drug copayment will apply based on the option selected at plan inception. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket have been met. Out-of-network benefits are accumulated separately.

\*\*\*Required for employers who average 51 or more total employees, including seasonal and/or part-time employees, during the prior calendar year

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

Medicare Part D 28% Subsidy – For the prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?     Yes     No

## IV. RATE INFORMATION

**Monthly Rates:** All new groups are subject to the four-tier rate structure indicated below. Rates must be included in the spaces below for application processing. Please note: All four categories must be completed.

Single	Couple	Parent/Children	Family
\$ 869.11	\$ 1912.04	\$ 1612.16	\$ 2753.59

## V. BROKER/AGENT INFORMATION

	Broker	Co-Broker	General Agent
1. Name of Payee:	SANDRA SALMON		NO GENERAL AGENT
2. Payee's Oxford Broker Code (Required):	BN3895		
3. Payee's Social Security # or Federal Tax ID # :			
4. Name of Writing Agent (Required if Payee is a company):	SANDRA SALMON		
5. Writing Agent's Oxford Broker Code (Required if Payee is a company):	BN3895		
6. Commission Split % :	3.0		0.0
7. Sales Representative:	Matthew Faltings		
Comments:			

## VI. CONSENT

### AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford to accept the Broker or General Agent named above as an authorized Benefits Administrator for purposes of processing any enrollment transactions for my company's Oxford policy (including, but not limited to, Member enrollments, Member terminations, Member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations).

This authorization shall be effective immediately and shall (check one only):

Remain in place until it is expressly revoked by me in writing.

Remain in place until \_\_\_\_\_.  
DATE

Further, I agree that my company will be bound by the actions performed by the herein-named Broker or General Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about any Member. I acknowledge that I must notify Oxford in writing to void this agreement in the event of a change in my company's Broker of Record.

## VII. COBRA & EXTENSION OF BENEFITS DATA

1. Do you have any individuals currently on COBRA continuation?  Yes  No  
If yes, identify the number of individuals 0.
2. Are there any dependents of employees who are currently disabled or in the hospital?  Yes  No

What is the length of the prior carrier's extension of benefits period for disabled employees or dependents? \_\_\_\_\_

## VIII. APPLICANT AGREEMENT

This Application and the premium rates proposed by Oxford are subject to approval, in writing, by Oxford and may change due to differences in actual versus proposed enrollment, selection of benefits, changes in census data or underwriting criteria, or any other changes in underwriting as determined by Oxford. We reserve the right to modify rates in the event a plan design must be modified as a result of any change, modification or clarification in law. We also retain the right to correct typographical errors or discrepancies prior to the effective date of coverage, and take other actions (for example due to a misrepresentation of a material fact) as permitted by applicable state law.

I, the undersigned, on behalf of the above named company (the "Applicant") am applying for small group health coverage and understand that the information provided will be used to determine eligibility for coverage, premium rates and for other purposes. I confirm that all information gathered herein is accurately represented, complete, and that the Applicant is not aware of any information that was not disclosed.

The Applicant confirms that we employ no more than 50 eligible active permanent employees and no fewer than 2 eligible active permanent employees. The Applicant understands that 1099-compensated individuals are not eligible for group coverage with Oxford.

The Applicant understands that this Application may be chosen for an audit to confirm the information provided. Audits may be conducted before or after enrollment. If documents reviewed or submitted during an audit show that the information provided on an application was false or that the group does not meet underwriting requirements, the group will not be enrolled (audit completed prior to enrollment) or will be terminated (audit completed post enrollment).

The Applicant understands that other audits may be conducted while the Group Policy and Group Enrollment Agreement is in effect and agrees that all documents or other information that may impact coverage or premiums will be available for inspection.

The Applicant hereby acknowledges and understands that this application does not constitute any obligation by Oxford to offer coverage and no insurance will be effective unless and until the application is formally accepted, in writing, by the Oxford entity underwriting the coverage. The Applicant hereby confirms that it will not cancel any current health coverage it may currently have in anticipation that this application will be accepted by Oxford. 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 completion and/or submission of this Application. Further, I hereby certify on behalf of the Applicant that the Applicant has not had a group health policy or health maintenance organization contract terminated within the past 12 months due to failure to pay premiums.

If coverage is formally accepted, the Applicant understands that this application and any subsequent addenda (including, but not limited to, any member application forms and renewal certifications) will become part of the Group Policy and Group Enrollment Agreement issued by Oxford. Any material misrepresentation within the application or the addenda (whether intentional or unintentional) may subject the group to termination or other action permitted by law. By signing below, the Applicant agrees to be bound by the terms and conditions of the Group Policy and Group Enrollment Agreement. The plan documents (including, but not limited to, the application, policy certificate(s) and riders) will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan, and will govern in the event they conflict with any benefits comparison, summary of coverage or other description of the plan.

The Applicant agrees to offer coverage to all eligible employees and that only those employees or former employees and their spouses or dependants who are eligible for coverage will be enrolled.

For groups seeking to purchase insurance, rather than Oxford HMO coverage, the Applicant agrees that Oxford Health Insurance, Inc. will be the only health insurer (other HMO coverage allowed) for all eligible employees who work in the state of New York as well as any other eligible employees located outside the state of New York who are eligible for coverage under a New York group health benefits plan.

By signing below, you are signing the group application on behalf of the group applying for coverage and stating that (1) I am the Applicant or the agent for the Applicant and am authorized to sign this Group Application and (2) the Applicant will be legally bound by the terms and conditions of the application, this authorization and the plan documents.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 dollars and the stated value of the claim for each violation.**

Dated at: VERATEX this 15th day of December 20 13.

Full legal name of firm: VERATEX

 *Claude Simon*

President

Signature of Authorized Company Representative

Title

Witness

Duly Licensed Resident Agent/Broker