Oxford Health Plans®

Connecticut Small Group Application

Oxford Health Plans (CT), Inc.

Corporate Address: 48 Monroe Turnpike, Trumbull, CT 06611 • www.oxfordhealth.com

I. GENERAL INFORMATION

1. Full legal name of company:

2. Address of company:
(Street Address
City, State, Zip Code **Please* -
Do not use a PO Box.)

3. Plan Administrator/Contact:

a. Name and Title: Samuel H Fleet President

b. Address:
(If different from address of company)
New England Benefit Cos.
16 International Way
Warwick, RI 02886-1706

c. Phone Number: Area Code 401 7393330

d. Fax Number Area Code 401 7395971

e. E-mail Address SFleet@nebenefit.com

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

a. Name:

b. Title: SAME

c. Address: AS #3
(Street Address
City, State, Zip Code) ABOVE

d. Phone Number:

e. Fax Number:
Area Code

5. Start Date of Business:
Area Code

6. Full legal name and address of parent company:

a. Name:

b. Address:

7. Full legal name & address of each subsidiary and/or affiliated company, branch or satellite office whose employees are to be covered:

Name of Company _____

8. **Nature of business:**

9. **SIC Code filed with the State of CT:**

10. **Type of Organization:** ❒ **Corporation** ❒ **Partnership** ❒ **Proprietorship** ❒ **LLC** ❒ **Other** _____

11. **Tax identification Code or Number:**

    a. Federal I.D. _____

    b. State Tax I.D. _____

12. **Is your group subject to:**

    a. **COBRA (20+ lives)?** ❒ **Yes** ☑ **No**

    b. **State Continuation (<20 lives)?** ☑ **Yes** ❒ **No**

13. **Did your group employ at least 2 but no more than 50 employees for at least 50% of your business days during the preceding 12 months?** ❒ **Yes** ❒ **No**

II. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate.

1. **Effective date:** We request that this coverage be effective as of the first day of _____ (Month/Year).

2. **Anniversary date:** The anniversary date will fall annually on the first day of the calendar month of the approved effective date. **(renews every May)**

3. **Other group health or individual coverage:** Indicate below other coverage which is still in force or that which has terminated within the past three (3) years.

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

4. **Employer Contributions:** Toward Employee Premium: _____%
   Toward Family Premium: _____%

5. **Eligibility and Termination:** Each employee must be eligible on the date the insurance provided under the Certificate becomes effective with respect to him/her. If the employee is not eligible for coverage on the date the Certificate becomes effective, the employee must wait until he/she is eligible for coverage.

   a) **Employee Eligibility :**

   Full Time Employees: All permanent, full-time employees who work at least 30 hours per week, including business owners and principals (minimum 30 hours/week).

Name of Company _____

Defining Eligible Employees (continued)

Retired Employees: ☑ Covered ☐ Not Covered

The definition of a Retired Employee is:

- ☐ an employee who is retired and on pension by the employer.
- ☐ an employee who is retired and on pension by the employer and who immediately prior to the date of retirement had completed at least ____ years of service with the employer.
- ☑ an employee who is retired from service by the employer and who immediately prior to the date of retirement had completed at least 1 years of service with the employer.

b) **Eligibility & Termination:** The employee will become eligible on the latter of the effective date of this plan or the date selected below

*Indicate number of months or days, whichever is applicable, in the space provided below. In (i) below, if there is no waiting period, insert "0" in the space provided for the number of days or months of continuous service. In (ii) below, indicate whether eligibility is first day of the calendar month coinciding with or next following the date on which the employee completes the group specified length of continuous service.

CLASS I

Definition of Class I all employees/owners

i) Eligibility

☐ Date on which the employee completes:

*_____ month(s) of continuous service, or

*_____ days of continuous service.

Termination

☐ Date of termination of employment

ii) Eligibility

☑ On the first day of the calendar month coinciding with or next following the date on which the employee completes:

*_____ month(s) of continuous service, or

*_____ days of continuous service.

Termination

☑ On the last day of the calendar month in which employee's employment terminates.

iii) Waiting Period for Rehires

Waiting Period Waived for Rehires? ☑ **Yes** ☐ **No**
If yes, waived if rehired within 6 **months.**

iv) Waiting Period for Full-Time Employees

Waiting Period Waived for existing Full-time employees?
☐ **Yes** ☐ **No**

v) Dependent Cut-Off

☐ End of Semester
☐ End of Calendar Year
☐ Other (requires Home Office approval)
✓ 11/30

N/A CLASS II

Definition of Class II _____

i) Eligibility

☐ Date on which the employee completes:

*_____ month(s) of continuous service, or

*_____ days of continuous service.

Termination

☐ Date of termination of employment

ii) Eligibility

☐ On the first day of the calendar month coinciding with or next following the date on which the employee completes:

*_____ month(s) of continuous service, or

*_____ days of continuous service.

Termination

☐ On the last day of the calendar month in which employee's employment terminates.

iii) Waiting Period for Rehires

Waiting Period Waived for Rehires? ☐ **Yes** ☐ **No**
If yes, waived if rehired within _____months.

iv) Waiting Period for Full-Time Employees

Waiting Period Waived for existing Full-time employees?
☐ **Yes** ☐ **No**

v) Dependent Cut-Off

☐ End of Semester
☐ End of Calendar Year
☐ Other (requires Home Office approval)

Name of Company _____

6. **Number of Total Employees the Effective Date:**

   Full-time Employees _____ Part-time Employees _____ Retired Employees _____

   Of the Total employees: How many are active eligible full-time employees who work in CT? _____

7. **Coordination of Benefits:** To the extent permitted by law, all health expense benefits will be coordinated with benefits under any No-Fault Auto Plan, under any other Group Plan and under any Group-Type Plan.

8. **Integration with Medicare Benefits:** Health Benefits will be integrated with Medicare Benefits for Retired Employees age 65 or over and their dependents age 65 or over if the group offers retiree coverage.

9. **Dependent Eligibility:** Dependents are defined as follows:

   • a legal spouse; and

   • any child;
   – who has not reached age 19 or the limiting age; and
   – who is not married; and
   – who is chiefly dependent upon the employee for support.

   The term "child" means the employee's children, including any legal stepchild, legally or proposed adoptive child who is physically placed in subscribers home, or child for whom the employee or employee's spouse is the court appointed legal guardian.

   If a child is a registered full-time student at a university, college, or similar institution of higher learning, then that child will be covered until the earlier of:

   – no longer being a registered full-time student:
   – reaching the age of: ❒ 23(standard) *or* ☑ 25(non-standard, additional cost) (select one)

   If a child cannot support him/herself due to mental or physical handicap, the age limitation requirement for such a child is waived provided that the disability or handicap arose prior to attaining the limiting age and the child is chiefly dependent upon the subscriber for economic support and maintenance, provided proof of such incapacity and dependency is furnished to Oxford Health Plans within thirty-one (31) days of the child's attaining the limiting age. However, the child must have been covered under this plan or the prior plan on the day before his/her attaining the limiting age.

10. **Plan Exclusions and Limitations:** Please refer to your Group Certificate for a complete list of exclusions and limitations.

III. PRODUCT / PLAN DESIGN

1. **Please select a plan type and a plan number (if applicable):**

❑ Blue Ribbon Plan Design (HMO Gatekeeper)

1.	**Office Copayment**	$10
2.	**Inpatient Facility Copay**	$500 Per Admission not to exceed 50% of the charge for the services provided
3.	**Skilled Nursing Facility Copay**	$500 Per Admission not to exceed 50% of the charge for the services provided
4.	**Emergency Room Copay**	$25
5.	**Durable Medical Equipment Copay**	$400 Per Item
6.	**Prosthesis Copay**	$400 Per Item, waived for internal prosthesis
7.	**Physical Therapy Limit**	30 Visits per prescribed course of treatment
8.	**Pharmacy (includes Contraceptives)**	
	a. Generic/Brand copay	$5
	b. Limit	$1,000
9.	**Dependent age cutoff**	19/23
10.	**Out of Pocket for covered services**	$1,500 single / $3,000 family

***Please Note*: If Blue Ribbon Plan Design was selected, the following options are not available.**

Name of Company _____

❑ Freedom Plan Gatekeeper ❑ Freedom Plan non Gatekeeper

(Deductibles and Out-of-Pocket Accumulation Periods are on a Calendar Year basis.)

Options:	I. ❐	II. ❐	III. ❐	IV. ❐	V. ❐	VI. ❐
Office Copayment:	$10	$10	$15	$15	$15	$20
Inpatient Hospital Copay (None standard):	❐ $250			❐ $500		
Deductibles:						
Single:	$250	$500	$300	$1,000	$500	$1,000
Family:	$625	$1,250	$750	$2,500	$1,250	$2,500
Coinsurance:	80%	70%	80%	70%	70%	70%
Coinsurance Maximum:	$5,000	$10,000	$5,000	$10,000	$10,000	$10,000

N/A ❑ HMO Gatekeeper N/A ❑ HMO non Gatekeeper

Options:	VII. ❐	VIII. ❐	IX. ❐	X. ❐
Office Copayment:	$5	$10	$15	$20

2. Please select a Prescription rider and desired coverages:
***Please Note*: If Blue Ribbon Plan Design was selected, the following options are not available.**

Standard coverages:
Contraceptives: ❐ Yes (Standard) or ❐ No (Qualified State Exempt Groups Only) N/A

Drug Riders:	❐	❐	❐	❐	❐	❐	❐	❐	❐
Copayment Generic:	$5	$5	$7	$5	$5	$7	$10	None	Other
Copayment Preferred Brand:	$10	$15	$20	$10	$15	$15	$20		
Copayment Non-Preferred Brand:	N/A	N/A	N/A	$25	$35	$35	$35		
Prescription Deductible:	No	No	No	No	No	No	No		

3. Please select any other additional riders:
***Please Note*: If Blue Ribbon Plan Design was selected, the following options are not available.**

N/A

❐ Vision: ❐ 60 Visits Physical Therapy (90 Visits standard)
❐ Dental Plan Premium
❐ Dental Plan Enhanced ❐ Prosthetics
❐ Emergency Room Copay ❐ $25 ❐ $30 ❐ $35 ❐ $50 (Standard)
❐ Hospital Copay ❐ $250 ❐ $500 ❐ None (Standard)

❐ Other: _____

_____

IV. UNDERWRITING GUIDELINES

The undersigned authorized officer of the Applicant hereby confirms that the Applicant satisfies, and if this Application is accepted by Oxford, will continue to satisfy and remain in compliance with the Underwriting Guidelines set forth in Attachment A, hereto, and any additional underwriting guidelines that Oxford may promulgate and which Applicant is given notice of in conjunction with future renewals. The Applicant hereby acknowledges that if at any time it is not in compliance with such underwriting guidelines or if any census data provided by the Applicant to Oxford, in conjunction with this Application for coverage do not accurately reflect, in the judgment of Oxford, the actual Applicant members covered by Oxford, on the date coverage by Oxford first commences, then Oxford shall have the right, at any time upon 30 days written notice to the Applicant, to increase the monthly premiums payable by the Applicant in such amount as is determined by Oxford, in its absolute discretion, to reflect the increased risk of such non-compliance or census variance.

_____
Name of Applicant (legal name of business)

_____
Signature of Authorized Officer of Applicant Title of Officer of Applicant Date

Name of Company _____

1. Are there any employees or dependents of employees who are covered under COBRA or State Continuation on your current plan? ❒ **Yes** ❒ **No**

   If yes, identify the number of individuals _____

2. Are there any employees or 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? _____

V. BROKER/AGENT INFORMATION

		BROKER	GENERAL AGENT
1.	**Full legal name of firm:**	New England Benefit Companies	
2.	**Address of firm:**	16 International Way	
		Warwick, RI 02886-1706	
3.	**Contact:**	Samuel H. Fleet, or NEBCO employee	
4.	**Telephone/Fax Number:**	(401)739-3330 / (401)739-5971	
5.	**Social Security # or Fed. Tax ID #:**		
6.	**Broker and/or Agent ID Number:**	BC2180	
7.	**Broker and/or Agent Commission %:**	100%	

8. **Account Executive:** Cindy Angon **Field Office:** Trumbull, CT **Phone Number:** (203)459-6766

VI. APPLICANT AGREEMENT

This Application and the premium rates proposed by Oxford are **subject to Home Office approval, in writing, by Oxford** and may change due to differences in actual versus proposed enrollment, selection of benefits, changes in census data or underwriting criteria, or any other changes in underwriting as determined by Oxford. The Applicant hereby acknowledges that **this Application does not constitute any obligation by Oxford to offer coverage to the Applicant until such Application is accepted, in writing, by the Home Office of Oxford**. The Applicant acknowledges that the Effective Date of Coverage is not guaranteed and is subject to receipt by Oxford of full requirements including completed Family Health Statements for all employees and their dependents enrolling for 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, and that **Oxford shall have no obligation to provide coverage to the Applicant unless this Application is formally accepted, in writing, by the Oxford Home Office**.

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: _____this_____day of _____20_____.

_____
Applicant Name (Correct Legal Name)

X _____
Signature of Authorized Officer of the Applicant — Title of Officer of Applicant

X _____ X _____
Witness — Duly Licensed Resident Agent/Broker

Thank you for choosing an Oxford health care plan for your employees.

We want you to be aware of an important State of Connecticut legislation amendment regarding medical loss ratio. Public Act 09-46 changes the definition of the term and requires disclosure of medical loss ratio to insurance applicants.

As of October 1, 2009, health insurers are required to include a written notice of their medical loss ratio with each individual or group health insurance application for coverage, as reported in the last Consumer Report Card on Health Insurance Carriers in Connecticut.

Please share the following information with employees at the time of their application for Oxford coverage:

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut. It limits claims to medical expenses for services and supplies provided to members, excluding expenses for stop loss coverage, reinsurance, member educational programs, and other cost containment programs or features. The medical loss ratio for Oxford Health Plans (CT) for calendar year 2008 is 81.48 percent. The medical loss ratio for Oxford Health Insurance, Inc. is 83.1 percent.

Going forward, our Web site at *www.oxfordhealth.com* will be updated annually with our most current medical loss ratio information.

If you have questions regarding this new Public Act, please contact Oxford Client Services.

Sincerely,

Oxford