Oxford Health Plans®

Connecticut Small Group Application-OHI

Oxford Health Insurance, Inc.

Corporate Address: 48 Monroe Turnpike, Trumbull, CT 06611
Mailing Address: 14 Central Park Drive, Hooksett, NH 03106 • 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:

b. Address:
(If different from address of company)

c. Phone Number:
Area Code

d. Fax Number:
Area Code

e. E-mail Address:

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

a. Name:

b. Title:

c. Address:
(Street Address
City, State, Zip Code)

d. Phone Number:
Area Code

e. Fax Number:
Area Code

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

Name of Company_____

6. **Nature of business:**

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

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

9. **Tax identification Code or Number:** Federal I.D. _____

10. **Did your group employ at least 1 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.

3. **Other group health or individual coverage:** Any other health coverage (including Medicare) while enrolled with Oxford should be indicated on the individual Member Enrollment Forms.
Please Note: Do not cancel existing coverage until you have received acceptance of this coverage by Underwriting.
If no previous coverage, initial here _____.

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: ❑ Please check here to confirm that all permanent full-time employees work a minimum 30 hours/week. Also, if the minimum hours are more than the required 30 hours, please enter the hours per week here _____.

   Retired Employees: ❑ Covered ❑ Not Covered

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

Name of Company_____

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 _____

_____

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.

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.

6. Number of Total Employees the Effective Date:

Full-time employees _____ Part-time employees _____ Retired employees _____
Of the total employees: Were 51% or more active eligible full-time employees working 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 coordinated with Medicare benefits for any employee over the age of 85 who is not actively at work.

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" refers to 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 Insurance 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.

Name of Company_____

III. PRODUCT / PLAN DESIGN

Please select one plan from either Section 1 or Section 2

SECTION 1: Oxford USA - Plan Designs

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

Options	❑ Plan 1	❑ Plan 2	❑ Plan 3	❑ Plan 4	❑ Plan 5	❑ Plan 6
Copayment	$10	$10	$15	$15	$15	$20
Single Deductible	$250	$500	$300	$1,000	$500	$1,000
Family Deductible	$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

2. Please select a Prescription rider and desired coverages:

Pharmacy benefit: (Generic/ Preferred Brand/ Non-Preferred Brand copay)*

❒ $5/$10/$10
❒ $5/$15/$15
❒ $7/$20/$20
❒ $5/$10/$25
❒ $5/$15/$35
❒ $7/$15/$35
❒ $10/$20/$35
❒ None

*All pharmacy benefits do not require a deductible.

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

3. Additional Benefit Information

❒ Vision
❒ None (Standard) Hospital copayment
❒ $250 Hospital copayment
❒ $500 Hospital copayment

❒ Other: _____

_____
SUBJECT TO HOME OFFICE APPROVAL

Please Note: Dental plans are not available for Oxford USA. Deductibles and Out-of-pocket Accumulation periods are on a calendar year basis.

Name of Company_____

III. PRODUCT / PLAN DESIGN (continued)

SECTION 2: Freedom Plan Value Option - Plan Designs

1. Please select a plan type:

In-network	❑ Plan A	❑ Plan B	❑ Plan C	❑ Plan D	❑ Plan E	❑ Plan F	❑ Plan G	❑ Plan H
PCP/Specialist copayment	$15	$20	$20	$20	$15/$30	$20/$40	$20/$40	$20/$40
Single Deductible	$1,500	$2,500	$3,500	$5,000	$1,500	$2,500	$3,500	$5,000
Family Deductible	$3,000	$5,000	$7,000	$10,000	$3,000	$5,000	$7,000	$10,000
Coinsurance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Maximum	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Out-of-network copayment	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Single Deductible	$3,000	$5,000	$7,000	$10,000	$3,000	$5,000	$7,000	$10,000
Family Deductible	$6,000	$10,000	$14,000	$20,000	$6,000	$10,000	$14,000	$20,000
Coinsurance	70%	70%	70%	70%	70%	70%	70%	70%
Coinsurance Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

Please refer to your summary of coverage for a more detailed explanation of your plan design.

2. Please select a Prescription rider and desired coverages:

Pharmacy benefit: (Generic/ Preferred Brand/ Non-Preferred Brand copayment)

❒ $7/$20/$20 ❒ $10/$20/$35
❒ 50%/50%/50% (excludes mail order) ❒ None

Deductible Options (Deductible is waived for generic drugs)
❒ None ❒ $50 ❒ $100 ❒ $150 ❒ $250

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

3. Additional Benefit Information

❒ Vision
❒ Unlimited Skilled Nursing Facility ❒ 30 Visit (Standard) Skilled Nursing Facility
❒ $75 (Standard) Emergency room copayment ❒ $150 Emergency room copayment

❒ Other: _____

_____

SUBJECT TO HOME OFFICE APPROVAL

Please Note: Dental plans are not available for Freedom Plan Value Option plans. Deductibles and out-of-pocket accumulation periods are on a calendar year basis.

Name of Company_____

IV. BROKER/AGENT INFORMATION

	BROKER	GENERAL AGENT
1. Full legal name of firm:		
2. Address of firm:		
3. Contact:		
4. Telephone/Fax Number:		
5. Social Security # or Fed. Tax ID #:		
6. Broker and/or Agent ID Number:		
7. Broker and/or Agent Commission %:		

8. Account Executive:_____ **Field Office:**_____ **Phone Number:** _____

V. CONSENT

AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford Health Insurance 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 Health Insurance 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 Oxford 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.

VI. 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 Company

_____
Signature of Authorized Officer of Company | Title of Officer of Company | Date

Name of Company_____

VII. 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.

X

Signature of Authorized Officer of the Applicant | Title of Officer of Applicant | Date

X

Duly Licensed and Appointed Producer* | Date

***Please note: If you are not currently appointed by Oxford in CT, you must contact Oxford's Commissions Department at 888-666-6844 in advance of executing this application.**

Oxford Health Plans®

there is another way®

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