United Healthcare Oxford

Freedom Plan® Classic℠
Freedom Plan® Access℠
Freedom Plan® Direct℠
NJ Public Sector
Exclusive Plan
Liberty Plan℠ Classic
Liberty Plan℠ Access
Liberty Plan℠ Direct
Oxford® HSA Direct℠
Oxford® Metro Network Plans

New Jersey Large Employer Application – OHI

Oxford Health Insurance, Inc.

Mailing Address: 4 Research Drive, Shelton, CT 06484

I. General Information

1. **Full legal name of firm:**

2. **Address of firm:**
   (Street Address
   City, State, ZIP Code)
   Please do not use P.O. Box

3. **Plan Administrator/Contact:**
   a. Name and Title:
   b. Address:
   (If it differs from address of firm;
   cannot be a P.O. Box)
   c. Phone Number:
   Area Code
   d. Fax Number:
   Area Code
   e. Email 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. **Start date of business:**

6. **Full legal name and address of parent company:**
   a. Name:
   b. Address:
   (Street Address
   City, State, Zip Code)

7. **Full legal name & address of each subsidiary and/or affiliated company, branch or satellite office whose employees are to be covered:** (If more than one name & address, please attach a sheet of paper with the additional information.)
   a. Name:
   b. Address:
   (Street Address
   City, State, Zip Code)

Name of Company: _____

8. Nature of business:

9. SIC Code: _____

10. Type of Organization: ☐ Corporation ☐ Partnership ☐ LLC ☐ LLP ☐ Other _____

11. Tax Identification Code or Number:

a. Federal I.D. _____

b. State Tax I.D. _____

12. Enter the Prior Calendar Year Average Total Number of Employees _____

Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.

To calculate the annual average, add all the monthly employee totals together then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

13. Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees _____

For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year. In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.

14. Subject to ERISA? ☐ Yes ☐ No (Most private sector plans are ERISA plans)
If No, please indicate appropriate category:

☐ Church (Additional information needed)
☐ Federal Government
☐ Indian Tribe – Commercial Business
☐ Non-Federal Government (State, Local or Tribal Gov.)
☐ Foreign Government/Foreign Embassy
☐ Non-ERISA Other _____

15. Does your group sponsor a plan that covers employees of more than one employer? ☐ Yes ☐ No
If you answered Yes, then indicate which of the following most closely describes your plan:

☐ Professional Employer Organization (PEO)
☐ Governmental
☐ Multiple Employer Welfare Arrangement (MEWA)
☐ Church
☐ Taft Hartley Union
☐ Employer Association

16. Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)? ☐ Yes ☐ No

If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that Oxford Health Insurance, Inc. will not cover the co-employees under this group policy.

17. Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?
☐ Yes ☐ No

18. Do you have common ownership with any other businesses? ☐ Yes ☐ No

If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

Name of Company: _____

19. UnitedHealthcare's Leave of Absence (LOA) Policy; Eligibility for Medical Coverage

If the employee is on an employer approved leave of absence and the employer continues to pay required medical premiums, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e. temporarily laid-off). (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by local, state or federal rules.

If the employee's medical coverage terminates under this LOA policy, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?

___ Yes, we continue medical coverage during an approved leave of absence for full time* employees (as defined in section II).

___ No, we do not offer medical coverage during a leave of absence.

The Employer's decision to refuse to offer coverage cannot be based upon health status related factors.

II. Administrative information

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

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

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

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

   Toward Family Premium: _____ %

   Note: Employer contribution must be at least 50% toward Employee 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 _____ hours per week (minimum 30 hours/week).

   Are any classes excluded? ☐ Yes ☐ No

   If yes, indicate classes excluded: _____

   _____

   Part-time Employees: ☐ Yes, part-time employees who work at least _____ hours per week (minimum 20 hours per week).
   ☐ Not Covered

   Retired Employees: ☐ Covered ☐ Not Covered

   The definition of a Retired Employee is:

   - ☐ an employee who is retired on pension by the employer.
   - ☐ an employee who is retired 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____years of service with the employer.

Name of Company: _____

b) Eligibility & 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 _____

_____

i) Eligibility

Waiting Period (Please enter zero for no waiting period)

☐ * _____ month(s) of continuous service, or

☐ * _____ days of continuous service.

***90-day maximum**

Effective Date of Coverage (Please select one)

☐ Date on which the employee completes the waiting period.

☐ On the first day of the calendar month coinciding with completion of the waiting period. (e.g., the employee will complete the waiting period on 2/15 and will, therefore, be eligible to enroll on 2/1).

ii) Termination

☐ Date of termination of employment.

☐ 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 _____month(s).

iv) Waiting Period for Full-time Employees

Waiting Period Waived for existing Full-Time Employees?

☐ **Yes** ☐ No

v) Dependent Cut-Off

☐ End of Calendar Year

☐ Other (requires Home Office approval)

CLASS II

Definition of Class II _____

_____

i) Eligibility

Waiting Period (Please enter zero for no waiting period)

☐ * _____ month(s) of continuous service, or

☐ * _____ days of continuous service.

***90-day maximum**

Effective Date of Coverage (Please select one)

☐ Date on which the employee completes the waiting period.

☐ On the first day of the calendar month coinciding with completion of the waiting period. (e.g., the employee will complete the waiting period on 2/15 and will, therefore, be eligible to enroll on 2/1).

ii) Termination

☐ Date of termination of employment.

☐ 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 _____month(s).

iv) Waiting Period for Full-time Employees

Waiting Period Waived for existing Full-Time Employees?

☐ **Yes** ☐ No

v) Dependent Cut-Off

☐ End of Calendar Year

☐ Other (requires Home Office approval)

6. **Number of Employees Eligible on Effective Date:** Full-time Employees _____ Part-time Employees _____ Retired Employees _____

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. Refer to the Group Certificate for details of how benefits will be integrated.

Name of Company: _____

9. **Dependent Eligibility:** Dependents are defined as follows: • a legal spouse (includes Civil Union Partners); • a Domestic Partner (at the option of the Group) and • any child who has not reached age 26.

   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 cannot support himself/herself due to intellectual disability 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 Us within thirty-one (31) days of the child 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:** Common exclusions and plan provisions are attached to this Application. Please refer to your Group Certificate and Policy for a complete list of exclusions and limitations.

III. Product/plan design

Section 1: Classic, Access and Traditional Design Plans

1. **Please check the box corresponding to the product selected:**

   Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application specifying the additional information.

   - ☐ Liberty Schoolboard/Municipality Traditional Plan[2]
   - ☐ Liberty Schoolboard/Municipality Access Plan[2]
   - ☐ Liberty Schoolboard/Municipality Classic Plan[2]
   - ☐ Freedom Plan Classic[1]
   - ☐ Freedom Plan Access[1]
   - ☐ Freedom Schoolboard/Municipality Traditional Plan[1]
   - ☐ Freedom Schoolboard/Municipality Access Plan[1]
   - ☐ Freedom Schoolboard/Municipality Classic Plan[1]
   - ☐ Liberty Plan Classic[2]
   - ☐ Liberty Plan Access[2]

2. **Please complete section below (please mark N/A if not applicable):**

   Office Copayment: _____ Deductible: _____

   Coinsurance %: _____ Maximum Out-of-Pocket: _____

   Out-of-Network Reimbursement – Freedom: High, Very High or Standard Fee Schedule[1] _____

   Out-of-Network Reimbursement – Freedom: 140% Medicare rate with 50% Medicare rate for Lab and 45% Medicare rate for DME[2] _____

   Out-of-Network Reimbursement – Liberty: based upon 140% of Medicare rate with 50% Medicare rate for Lab and 45% Medicare rate for DME[2] _____

   Out-of-Network Reimbursement – Freedom Schoolboard/Municipality plans: based upon Very High fee schedule[1]

3. **Additional Benefit Information (All information is subject to Home Office approval):**

   Prescription Plan: ☐ Yes ☐ No

   Copayment Information:

   Deductible: _____

   Tier 1: _____ Tier 2: _____ Tier 3: _____

   Mail-Order Prescription Drug Plan: ☐ Yes ☐ No (if applicable) Oral Contraceptives: ☐ Yes ☐ No

   - ☐ Emergency Room Copayment _____
   - ☐ Domestic Partner
   - ☐ SimplyEngaged®
   - ☐ Other: _____
   - ☐ 90 Visits Physical Therapy (60 visits is standard)
   - ☐ Unlimited Skilled Nursing Facility (30 days is standard)
   - ☐ Inpatient/Outpatient Hospital Copayment

Name of Company: _____

III. Product/plan design (continued)

Section 2: Freedom Plan Direct and Liberty Plan Direct plan designs

No referrals are required for these plan designs.

1. **Please check the box corresponding to the product selected:**

   Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application specifying the additional information.

   ☐ Freedom Plan Direct (Office Visit Copayment)
   ☐ Freedom Plan Direct (Deductible & Coinsurance only)
   ☐ Liberty Plan Direct (Office Visit Copayment)
   ☐ Liberty Plan Direct (Deductible & Coinsurance only)

2. **Please complete section below (if applicable):**

   Office Visit Copayment: _____

   In-network

   Deductible: _____

   Coinsurance: _____

   Maximum Out-of-Pocket: _____

   Out-of-network

   Deductible: _____

   Coinsurance: _____

   Maximum Out-of-Pocket: _____

   Out-of-Network Reimbursement – Freedom: High, Very High or Standard Fee Schedule[1] _____

   Out-of-Network Reimbursement – Freedom: 140% Medicare rate with 50% Medicare rate for Lab and 45% Medicare rate for DME[2] _____

   Out-of-Network Reimbursement – Liberty: based upon 140% of Medicare rate with 50% Medicare rate for Lab and 45% Medicare rate for DME[2] _____

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

3. **Additional Benefit Information (All information is subject to Home Office approval):**

   Prescription Drug Plan: ☐ Yes ☐ No

   Copayment Information

   Deductible: _____

   Tier 1: _____ Tier 2: _____ Tier 3: _____

   Mail-Order Prescription Drug Plan: ☐ Yes ☐ No Oral Contraceptives: ☐ Yes ☐ No

   ☐ Emergency Room Copayment _____
   ☐ 90 Visits Outpatient Therapy (60 visits is standard)
   ☐ Unlimited Skilled Nursing Facility (30 days is standard)
   ☐ Domestic Partner
   ☐ SimplyEngaged®
   ☐ Other (Subject to Home Office Approval): _____

Name of Company: _____

III. Product/plan design (continued)

Section 3: Exclusive Plan (Liberty Network)

1. Please check the box corresponding to the product selected:

Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application specifying the additional information.

Please Select:

☐ **Exclusive Plan (Office Visit Copayment)**

☐ **Exclusive Plan (Office Visit Copayment with Deductible & Coinsurance)**

Please Note: No referrals are required for these plan designs.

2. Please complete section below (please mark N/A if not applicable):

Office Visit Copayment: _____

In-network

Deductible: _____

Coinsurance: _____

Maximum Out-of-Pocket: _____

Please Note: Family deductible and out-of-pocket expenses are two times the single amount.

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

3. Additional Benefit Information (All information is subject to Home Office approval):

Prescription Drug Plan: ☐ Yes ☐ No

Copayment Information

Deductible: _____

Tier 1: _____ Tier 2: _____ Tier 3: _____

Mail-Order Prescription Drug Plan: ☐ Yes ☐ No Oral Contraceptives: ☐ Yes ☐ No

☐ Unlimited Skilled Nursing Facility (30 days is standard)
☐ 90 Visits Outpatient Therapy (60 days is standard)
☐ Domestic Partner
☐ SimplyEngaged®
☐ Emergency Room Copayment: _____
☐ Inpatient/Outpatient Hospital Copayment: _____
☐ Other (Subject to Home Office Approval): _____

Name of Company: _____

III. Product/plan design (continued)

Section 4: Oxford HSA Direct Options

No referrals are required for these plan designs.

Groups enrolling in the Oxford HSA Direct are required to fill out a Certificate of Understanding Form (#8767). For groups electing to use Optum Bank®, an Oxford HSA Employer Notification Form (#7423) must be completed.

1. **Please select network:**

   ☐ Freedom ☐ Liberty

2. **Please complete section below:**

   Office Visit Copayment: _____

   In-network

   Deductible: _____

   Coinsurance: _____

   Maximum Out-of-Pocket: _____

   Out-of-network

   Deductible: _____

   Coinsurance: _____

   Maximum Out-of-Pocket: _____

   Out-of-Network Reimbursement – Freedom: High, Very High or Standard Fee Schedule[1] _____

   Out-of-Network Reimbursement – Freedom: 140% Medicare rate with 50% Medicare rate for Lab and 45% Medicare rate for DME[2] _____

   Out-of-Network Reimbursement – Liberty: based upon 140% of Medicare rate with 50% Medicare rate for Lab and 45% Medicare rate for DME[2] _____

   Prescription Drug Plan Required) * *

   Copayment Information

   Deductible: _____

   Tier 1: _____ Tier 2: _____ Tier 3: _____

   Mail-Order Prescription Drug Plan: ☐ Yes ☐ No Oral Contraceptives: ☐ Yes ☐ No

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

3. **Additional Benefit Information (All information is subject to Home Office approval):**

   ☐ 90 Visits Outpatient Therapy (60 visits is standard)

   ☐ Unlimited Skilled Nursing Facility (30 days is standard)

   ☐ Domestic Partner

   ☐ SimplyEngaged®

   ☐ 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 and prescription drug copayment will apply based on the option selected at plan inception. Out-of-network benefits are accumulated separately.

Name of Company: _____

III. Product/plan design (continued)

Section 5: Oxford Metro Plans (Metro Network)

1. Please check the box corresponding to the product selected:

Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application specifying the additional information.

Please Select:

- ☐ Oxford EPO (Office Visit Copayment)
- ☐ Oxford EPO (Office Visit Copayment with Deductible & Coinsurance)
- ☐ Oxford Gated EPO (Office Visit Copayment)
- ☐ Oxford EPO HSA
- ☐ Oxford EPO HSA (Office Visit Copayment)
- ☐ Oxford Primary Advantage

2. Please complete section below (please mark N/A if not applicable):

Office Visit Copayment: _____

In-network

Deductible: _____

Coinsurance: _____

Maximum Out-of-Pocket: _____

Please Note: Family deductible and out-of-pocket expenses are two times the single amount.

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

3. Additional Benefit Information (All information is subject to Home Office approval):

Prescription Drug Plan: ☐ Yes ☐ No

Copayment Information

Deductible: _____

Tier 1: _____ Tier 2: _____ Tier 3: _____

Mail-Order Prescription Drug Plan: ☐ Yes ☐ No Oral Contraceptives: ☐ Yes ☐ No

- ☐ Emergency Room Copayment (EPO plans only)
- ☐ Inpatient/Outpatient Hospital Copayment (EPO plans only)
- ☐ Unlimited Skilled Nursing Facility (30 days is standard)
- ☐ 90 Visits Outpatient Therapy (60 visits is standard)
- ☐ Domestic Partner
- ☐ SimplyEngaged®
- ☐ Other (Subject to Home Office Approval): _____

Name of Company:_____

IV. Underwriting guidelines

The undersigned authorized officer of the Applicant hereby acknowledges that if at any time the census data provided by the Applicant to Oxford, in conjunction with this Application for coverage does 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 census variance. All statements made by the applicant are to be true and complete to the best of the applicant's knowledge and belief.

Name of Company

X

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

V. COBRA and Extension of Benefits

1. Do you have any individuals currently on COBRA continuation? ☐ Yes ☐ No
   If Yes, identify the number of individuals_____.
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? _____

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 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. Further, I hereby certify on behalf of the applicant that the applicant has not had a health insurance policy terminated within the past 12 months due to failure to pay premiums. All statements made by the applicant are to be true and complete to the best of the applicant's knowledge and belief.

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Applicant's employees. This consent remains in effect until it is withdrawn. The Applicant may withdraw their consent at any time or request a document in a paper or non-electronic form.

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 (full legal Name)

X

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

X

Witness | Duly Licensed Resident Agent/Broker

[1]The Standard, High and Very High fee schedules contain the maximum allowable fees and are set using data from the Centers for Medicare and Medicaid Services (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees. Physician fees are generally set using data from FAIR Health, Inc. We use 70th percentile data for the standard fee schedule, 80th percentile data for the high fee schedule, and 90th percentile data for the very-high fee schedule. The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees. This applies to all out-of-network Covered Services except for those noted below:

- Inpatient & Outpatient Facility - 140% of Medicare
- Laboratory Services - 50% of Medicare
- Durable Medical Equipment - 45% of Medicare

When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.

[2]The fee schedule contains the maximum allowable fees and are set using data from the Centers for Medicare and Medicaid Services (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees. Physician fees are generally set using 140% of the Medicare Rate with 50% of the Medicare Rate for lab services and 45% of the Medicare Rate for durable medical equipment. When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.

The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees.