New Jersey Application for a Small Employer Health Benefits Policy

Oxford Health Insurance, Inc. (OHI)

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

Please print or type

Policy Number (OHP Use Only): ______________________

☐ **New Policy** ☐ **Change in Policy**

Requested Effective Date: ______________________

* Note: The effective date will be on or after the date Oxford approves the application.

I. Policyholder information

1. **Policyholder (**Full legal name of company):
2. **Tax identification number:**
3. **Main address:** Street / City / State / ZIP Code

   Mailing address: Street / City / State / ZIP Code

   Telephone & Facsimile: Fax

   Email Address: ______________________

   Contract information should be provided ☐ **electronically or** ☐ **hard copy. Check one.**
4. **Name of correspondent:**
5. **Type of organization:** ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain) ______________
6. **Nature of business (specify):** ______________________ **SIC Code:** ______________
7. **Number of full-time employees in your company:** ______________________

   Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.
8. **Number of full-time employees to be insured:** ______________________
9. **Class or classes to be excluded:** ______________________
10. **Insurance requested for:** ☐ Employees Only ☐ Employees and Dependents excluding Spouse ☐ Employees and Dependents including Spouse

    Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c.246 ☐ Yes ☐ No

    If yes, should the plan provide coverage for children of a covered domestic partner? ☐ Yes ☐ No
11. **Is the employer subject to the requirements of COBRA?** ☐ Yes ☐ No
12. **Is the employer subject to the requirements of Medicare as Secondary Payer rules for eligibility due to age?**

    ☐ Yes ☐ No

    Due to disability? ☐ Yes ☐ No

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I. Policyholder information (continued)

13. Orientation Period: ☐ Yes ☐ No

14. Waiting period before employees become insured (may not exceed 90 days):

Present employees ______________________ New or rehired employees ______________________

15. Period for Annual Employee Open Enrollment Period:______________________

16. What percentage of the premium will the employer pay? ______________________

17. Deposit $ ______________ **Premium Paid:** ☐ Monthly ☐ Quarterly

Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (must be included for purposes of participation)

Legal name and location	Number of full-time employees in this company	Number of full-time employees to be insured

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II. Specifications for coverage

Please select a plan from section A, B, C, D, E, F, G OR H.

A. Platinum Plans

Option	☐ NJ P FRDM NG 20/40/100 PPO 21 2	☐ NJ P LBTY NG 15/40/100 EPO 21 2	☐ NJ P LBTY NG 15/45/100 PPO 21 2	☐ NJ P FRDM NG 15/40/100 EPO 21 2
Network	Freedom	Liberty	Liberty	Freedom
Gated/Non-Gated	N	N	N	N
Copayment				
a. PCP	$20	$15	$15	$15
b. Specialist	$40	$40	$45	$40
In-Network Deductible (Single)	N/A	N/A	N/A	N/A
In-Network Deductible (Family)	N/A	N/A	N/A	N/A
In-Network Maximum Out of Pocket (Single)	$3,500	$3,500	$3,500	$3,500
In-Network Maximum Out of Pocket (Family)	$7,000	$7,000	$7,000	$7,000
In-Network Coinsurance	N/A	N/A	N/A	N/A
Outpatient Facility				
Freestanding	$10	$10	$10	$10
Hospital	$500	$500	$500	$500
Inpatient Facility	$200 per day up to $1,000 per admit	$300 per day up to $1,500 per admit	$300 per day up to $1,500 per admit	$250 per day up to $1,250 per admit
Emergency Room	$100	$100	$100	$100
Out of Network Deductible (Single)	$3,000	N/A	$3,000	N/A
Out of Network Deductible (Family)	$6,000	N/A	$6,000	N/A
Out of Network Maximum Out of Pocket (Single)	$7,500	N/A	$7,500	N/A
Out of Network Maximum Out of Pocket (Family)	$15,000	N/A	$15,000	N/A
Out of Network Coinsurance	30%	N/A	30%	N/A
Prescription Drug	Tier 1 - $5 Tier 2 - $25 Tier 3 - $50 Mail order = 2x copayment	Tier 1 - $5 Tier 2 - $25 Tier 3 - $50 Mail order = 2x copayment	Tier 1 - $5 Tier 2 - $25 Tier 3 - $50 Mail order = 2x copayment	Tier 1 - $5 Tier 2 - $25 Tier 3 - $50 Mail order = 2x copayment

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A. Platinum Plans (continued)

Option	☐ NJ P FRDM NG 20/40/100 PPO 21 1	☐ NJ P LBTY NG 15/40/100 EPO 21 1	☐ NJ P LBTY NG 15/45/100 PPO 21 1	☐ NJ P FRDM NG 15/40/100 EPO 21 1
Network	Freedom	Liberty	Liberty	Freedom
Gated/Non-Gated	N	N	N	N
Copayment				
a. PCP	$20	$15	$15	$15
b. Specialist	$40	$40	$45	$40
In-Network Deductible (Single)	N/A	N/A	N/A	N/A
In-Network Deductible (Family)	N/A	N/A	N/A	N/A
In-Network Maximum Out of Pocket (Single)	$2,500	$2,500	$2,750	$2,500
In-Network Maximum Out of Pocket (Family)	$5,000	$5,000	$5,500	$5,000
In-Network Coinsurance	N/A	N/A	N/A	N/A
Outpatient Facility				
Freestanding	$10	$40	100%	$40
Hospital	$150	$150	$150	$150
Inpatient Facility	$200 per day up to $1,000 per admit/$2,000 per year	$250 per day up to $1,250 per admit/$2,500 per year	$300 per day up to $1,500 per admit/$3,000 per year	$250 per day up to $1,250 per admit/$2,500 per year
Emergency Room	$100	$100	$100	$100
Out of Network Deductible (Single)	$2,000	N/A	$2,500	N/A
Out of Network Deductible (Family)	$4,000	N/A	$5,000	N/A
Out of Network Maximum Out of Pocket (Single)	$5,000	N/A	$6,250	N/A
Out of Network Maximum Out of Pocket (Family)	$10,000	N/A	$12,500	N/A
Out of Network Coinsurance	30%	N/A	30%	N/A
Prescription Drug	Tier 1 - $5 Tier 2 - $25 Tier 3 - $50 Mail order = 2x copayment	Tier 1 - $5 Tier 2 - $25 Tier 3 - $50 Mail order = 2x copayment	Tier 1 - $5 Tier 2 - $25 Tier 3 - $50 Mail order = 2x copayment	Tier 1 - $5 Tier 2 - $25 Tier 3 - $50 Mail order = 2x copayment

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

Additional Benefit Options:
☐ Domestic Partner

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

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B. Gold Plans

Option	☐ NJ G FRDM NG 25/60/1000/80 PPO 21	☐ NJ G FRDM NG 30/75/1500/80 PPO 21 1	☐ NJ G FRDM NG 50/50/1000/100 EPO 21	☐ NJ G LBTY GT 50/50/1000/100 EPO 21
Network	Freedom	Freedom	Freedom	Liberty
Gated/Non-Gated	N	N	N	Y
Copayment				
a. PCP	$25	$30	$50	$50
b. Specialist	$60	$75	$50	$50
In-Network Deductible (Single)	$1,000	$1,500	$1,000	$1,000
In-Network Deductible (Family)	$2,000	$3,000	$2,000	$2,000
In-Network Maximum Out of Pocket (Single)	$5,500	$5,000	$6,000	$6,000
In-Network Maximum Out of Pocket (Family)	$11,000	$10,000	$12,000	$12,000
In-Network Coinsurance	20%	20%	N/A	N/A
Outpatient Facility				
Freestanding	$100 after ded	$100	$100	$100
Hospital	50% after ded	50% after ded	50% after ded	50% after ded
Inpatient Facility	20% after ded	20% after ded	$500 per day up to $2,500 per admit	$500 per day up to $2,500 per admit
Emergency Room	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	$3,000	$4,000	N/A	N/A
Out of Network Deductible (Family)	$6,000	$8,000	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	$7,500	$9,000	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	$15,000	$18,000	N/A	N/A
Out of Network Coinsurance	40%	40%	N/A	N/A
Prescription Drug	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2 x copayment *After $100 Rx deductible"	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $100 Rx deductible"	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $100 Rx deductible"	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $100 Rx deductible"

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B. Gold Plans (continued)

Option	☐ NJ G LBTY NG 25/50/1000/50 EPO 21 1	☐ NJ G LBTY NG 25/60/1500/80 EPO 21 1	☐ NJ G LBTY NG 25/60/1500/70 EPO 21 1	☐ NJ G LBTY NG 30/75/1500/80 EPO 21 1
Network	Liberty	Liberty	Liberty	Liberty
Gated/Non-Gated	N	N	N	N
Copayment				
a. PCP	$25	$25	$25	$30
b. Specialist	$50	$60	$60	$75
In-Network Deductible (Single)	$1,000	$1,500	$1,500	$1,500
In-Network Deductible (Family)	$2,000	$3,000	$3,000	$3,000
In-Network Maximum Out of Pocket (Single)	$5,000	$5,000	$5,500	$5,500
In-Network Maximum Out of Pocket (Family)	$10,000	$10,000	$11,000	$11,000
In-Network Coinsurance	50%	20%	30%	20%
Outpatient Facility				
Freestanding	$100	$100	70% after ded	80% after ded
Hospital	50% after ded	50% after ded	70% after ded	50% after ded
Inpatient Facility	50% after ded	20% after ded	30% after ded	20% after ded
Emergency Room	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	N/A	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A	N/A
Prescription Drug	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $100 Rx deductible"	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $75 Rx deductible"	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $100 Rx deductible"	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $75 Rx deductible"

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B. Gold Plans (continued)

Option	☐ NJ G LBTY NG 30/65/1500/80 PPO 21 1	☐ NJ G LBTY NG 50/50/1000/100 EPO 21	☐ NJ G LBTY NG 30/50/2000/50 EPO 21 2	☐ NJ G LBTY NG 35/60/2000/70 PPO 21
Network	Liberty	Liberty	Liberty	Liberty
Gated/Non-Gated	N	N	N	N
Copayment				
a. PCP	$30	$50	$30	$35
b. Specialist	$65	$50	$50	$60
In-Network Deductible (Single)	$1,500	$1,000	$2,000	$2,000
In-Network Deductible (Family)	$3,000	$2,000	$4,000	$4,000
In-Network Maximum Out of Pocket (Single)	$5,500	$6,000	$6,000	$7,500
In-Network Maximum Out of Pocket (Family)	$11,000	$12,000	$12,000	$15,000
In-Network Coinsurance	20%	N/A	50%	30%
Outpatient Facility				
Freestanding	$100	$100	50% after ded	70% after ded
Hospital	50% after ded	50% after ded	50% after ded	70% after ded
Inpatient Facility	20% after ded	$500 per day up to $2,500 per admit	50% after ded	30% after ded
Emergency Room	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	$4,000	N/A	N/A	$4,500
Out of Network Deductible (Family)	$8,000	N/A	N/A	$9,000
Out of Network Maximum Out of Pocket (Single)	$9,000	N/A	N/A	$10,000
Out of Network Maximum Out of Pocket (Family)	$18,000	N/A	N/A	$20,000
Out of Network Coinsurance	40%	N/A	N/A	50%
Prescription Drug	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $75 Rx deductible"	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $100 Rx deductible"	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $75 Rx deductible"	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $75 Rx deductible"

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B. Gold Plans (continued)

Option	☐ NJ G LBTY NG 1500/90 EPO HSAM 21	☐ NJ G LBTY NG 30/50/2000/50 EPO 21 1	☐ NJ G LBTY NG 35/60/1500/70 PPO 21	☐ NJ G FRDM NG 25/60/1250/80 PPO 21
Network	Liberty	Liberty	Liberty	Freedom
Gated/Non-Gated	N	N	N	N
Copayment				
a. PCP	90% after ded	$30	$35	$25
b. Specialist	90% after ded	$50	$60	$60
In-Network Deductible (Single)	$1,500	$2,000	$1,500	$1,250
In-Network Deductible (Family)	$3,000	$4,000	$3,000	$2,500
In-Network Maximum Out of Pocket (Single)	$5,000	$5,750	$7,150	$5,500
In-Network Maximum Out of Pocket (Family)	$10,000	$11,500	$14,300	$11,000
In-Network Coinsurance	10%	50%	30%	20%
Outpatient Facility				
Freestanding	90% after ded	50% after ded	70% after ded	$100
Hospital	90% after ded	50% after ded	70% after ded	50% after ded
Inpatient Facility	10% after ded	50% after ded	30% after	20% after ded
Emergency Room	$100 then 50% after ded	$100 then 50%	$100 then 70%	$100 then 50% after ded
Out of Network Deductible (Single)	N/A	N/A	$4,500	$3,000
Out of Network Deductible (Family)	N/A	N/A	$9,000	$6,000
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	$10,000	$7,500
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	$20,000	$15,000
Out of Network Coinsurance	N/A	N/A	50%	40%
Prescription Drug	"Tier 1 - $5* Tier 2 - $50* Tier 3 - 50%* Mail order = 2x copayment *After medical deductible "	"Tier 1 - $20 Tier 2 - $50 Tier 3 - $75 Mail order = 2x copayment"	"Tier 1 - $20 Tier 2 - $50 Tier 3 - $75 Mail order = 2x copayment"	"Tier 1 - $5 Tier 2 - $35* Tier 3 - $75* Mail order = 2x copayment *After $100 Rx deductible"

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B. Gold Plans (continued)

Option	☐ NJ G LBTY NG 25/60/1500/80 EPO 21 2	☐ NJ G LBTY NG 30/65/1500/80 PPO 21 2	☐ NJ G LBTY NG 30/75/1500/80 EPO 21 2	☐ NJ G LBTY NG 25/60/1500/70 EPO 21 2
Network	Liberty	Liberty	Liberty	Liberty
Gated/Non-Gated	N	N	N	N
Copayment				
a. PCP	$25	$30	$30	$25
b. Specialist	$60	$65	$75	$60
In-Network Deductible (Single)	$1,500	$1,500	$1,500	$1,500
In-Network Deductible (Family)	$3,000	$3,000	$3,000	$3,000
In-Network Maximum Out of Pocket (Single)	$5,000	$5,500	$4,500	$5,500
In-Network Maximum Out of Pocket (Family)	$10,000	$11,000	$9,000	$11,000
In-Network Coinsurance	20%	20%	20%	30%
Outpatient Facility				
Freestanding	$100	$100	80% after ded	70% after ded
Hospital	50% after ded	50% after ded	50% after ded	70% after ded
Inpatient Facility	20% after ded	20% after ded	20% after ded	30% after ded
Emergency Room	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	N/A	$4,000	N/A	N/A
Out of Network Deductible (Family)	N/A	$8,000	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	$9,000	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	$18,000	N/A	N/A
Out of Network Coinsurance	N/A	40%	N/A	N/A
Prescription Drug	"Tier 1 - $25 Tier 2 - $50 Tier 3 - $75 Mail order = 2x copayment"	"Tier 1 - $10 Tier 2 - $25 Tier 3 - $50 Mail order = 2x copayment"	"Tier 1 - $25 Tier 2 - $50 Tier 3 - $75 Mail order = 2x copayment"	"Tier 1 - $20 Tier 2 - $50 Tier 3 - $75 Mail order = 2x copayment"

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B. Gold Plans (continued)

Option	☐ NJ G FRDM NG 30/75/1500/80 PPO 21 2	☐ NJ G LBTY NG 25/50/1000/50 EPO 21 2
Network	Freedom	Liberty
Gated/Non-Gated	N	N
Copayment		
a. PCP	$30	$25
b. Specialist	$75	$50
In-Network Deductible (Single)	$1,500	$1,000
In-Network Deductible (Family)	$3,000	$2,000
In-Network Maximum Out of Pocket (Single)	$5,000	$5,000
In-Network Maximum Out of Pocket (Family)	$10,000	$10,000
In-Network Coinsurance	20%	50%
Outpatient Facility		
Freestanding	$100	$100
Hospital	50% after ded	50% after ded
Inpatient Facility	20% after ded	50% after ded
Emergency Room	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	$4,000	N/A
Out of Network Deductible (Family)	$8,000	N/A
Out of Network Maximum Out of Pocket (Single)	$9,000	N/A
Out of Network Maximum Out of Pocket (Family)	$18,000	N/A
Out of Network Coinsurance	40%	N/A
Prescription Drug	"Tier 1 - $10 Tier 2 - $25 Tier 3 - $50 Mail order = 2x copayment"	"Tier 1 - $25 Tier 2 - $50 Tier 3 - $75 Mail order = 2x copayment"

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

Additional Benefit Options:
☐ **Domestic Partner**

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

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C. Silver Plans

Option	☐ NJ S FRDM NG 2500/100 PPO HSA 21	☐ NJ S FRDM NG 50/75/2500/60 PPO 21	☐ NJ S LBTY NG 30/50/2000/80 EPO HSA 21 2	☐ NJ S LBTY NG 20/40/2000/60 PPO HSA 21
Network	Freedom	Freedom	Liberty	Liberty
Gated/Non-Gated	N	N	N	N
Copayment a. PCP b. Specialist	 No Charge after ded No Charge after ded	 $50 $75	 $30 after ded $50 after ded	 $20 after ded $40 after ded
In-Network Deductible (Single)	$2,500	$2,500	$2,000	$2,000
In-Network Deductible (Family)	$5,000	$5,000	$4,000	$4,000
In-Network Maximum Out of Pocket (Single)	$7,000	$8,550	$7,000	$6,000
In-Network Maximum Out of Pocket (Family)	$14,000	$17,100	$14,000	$12,000
In-Network Coinsurance	N/A	40%	20%	40%
Outpatient Facility Freestanding Hospital	 No Charge after ded 50% after ded	 $250 after ded 50% after ded	 $250 after ded 50% after ded	 $250 after ded 50% after ded
Inpatient Facility	$500 per day after ded up to $2,500	40% after ded	20% after ded	40% after ded
Emergency Room	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	$5,000	$5,000	N/A	$4,000
Out of Network Deductible (Family)	$10,000	$10,000	N/A	$8,000
Out of Network Maximum Out of Pocket (Single)	$13,700	$12,500	N/A	$8,000
Out of Network Maximum Out of Pocket (Family)	$27,400	$25,000	N/A	$16,000
Out of Network Coinsurance	50%	50%	N/A	50%
Prescription Drug	Tier 1 - $5* Tier 2 - $50* Tier 3 - 50%* Mail order = 2x copayment *After medical deductible	Tier 1 - $5 Tier 2 - $50* Tier 3 - 50%* Mail order = 2x copayment *After $250 Rx Ded	Tier 1 - $5* Tier 2 - $50* Tier 3 - 50% up to $150 maximum* Mail order = 2x copayment *After medical deductible	Tier 1 - $5* Tier 2 - $50* Tier 3 - 50% up to $150 maximum* Mail order = 2x copayment *After medical deductible

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C. Silver Plans (continued)

Option	☐ NJ S LBTY NG 40/75/2500/50 EPO 21	☐ NJ S LBTY NG 50/75/2500/60 PPO 21	☐ NJ S LBTY NG 2500/80 EPO HSAM 21	☐ NJ S LBTY NG 30/50/2000/80 EPO HSA 21 1
Network	Liberty	Liberty	Liberty	Liberty
Gated/Non-Gated	N	N	N	N
Copayment a. PCP b. Specialist	 $40 $75	 $50 $75	 20% after ded 20% after ded	 $30 after ded $50 after ded
In-Network Deductible (Single)	$2,500	$2,500	$2,500	$2,000
In-Network Deductible (Family)	$5,000	$5,000	$5,000	$4,000
In-Network Maximum Out of Pocket (Single)	$8,550	$8,550	$7,000	$6,550
In-Network Maximum Out of Pocket (Family)	$17,100	$17,100	$14,000	$13,100
In-Network Coinsurance	50%	40%	20%	20%
Outpatient Facility Freestanding Hospital	 $250 after ded 50% after ded	 $250 after ded 50% after ded	 20% after ded 20% after ded	 No Charge after ded $500 after ded
Inpatient Facility	50% after ded	40% after ded	20% after ded	$500 per day after ded up to $1,500
Emergency Room	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded	$100 then 20% after ded
Out of Network Deductible (Single)	N/A	$5,000	N/A	N/A
Out of Network Deductible (Family)	N/A	$10,000	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	$12,500	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	$25,000	N/A	N/A
Out of Network Coinsurance	N/A	50%	N/A	N/A
Prescription Drug	Tier 1 - $5 Tier 2 - $50* Tier 3 - 50%* Mail order = 2x copayment *After $250 Rx Ded	Tier 1 - $5 Tier 2 - $50* Tier 3 - 50%* Mail order = 2x copayment *After $250 Rx Ded	Tier 1 - $5* Tier 2 - $50* Tier 3 - 50%* Mail order = 2x copayment *After medical deductible	Tier 1 - $25* Tier 2 - $50* Tier 3 - 75* Mail order = 2x copayment *After medical deductible

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

Additional Benefit Options:
☐ Domestic Partner

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

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D. Bronze Plans

Option	☐ NJ B LBTY NG 5900/50 EPO HSA 21	☐ NJ B LBTY NG 10/70/6000/50 EPO HSA 21
Network	Liberty	Liberty
Gated/Non-Gated	N	N
Copayment		
a. PCP	50% after ded	$10 after ded
b. Specialist	50% after ded	$70 after ded
In-Network Deductible (Single)	$5,900	$6,000
In-Network Deductible (Family)	$11,800	$12,000
In-Network Maximum Out of Pocket (Single)	$6,900	$6,900
In-Network Maximum Out of Pocket (Family)	$13,800	$13,800
In-Network Coinsurance	50%	50%
Outpatient Facility		
Freestanding	50%	50%
Freestanding Ded	Y	Y
Hospital	50%	50%
Hospital Ded	Y	Y
Inpatient Facility	$100 per day after ded up to $500 per admit	$50 per day after ded up to $250 per admit
Emergency Room	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A
Out of Network Coinsurance	N/A	N/A
Prescription Drug	Tier 1 - 50%* Tier 2 - 50%* Tier 3 - 50%* *After medical deductible	Tier 1 - 50%* Tier 2 - 50%* Tier 3 - 50%* *After medical deductible

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

Additional Benefit Options:
☐ Domestic Partner

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

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E. Metro Platinum Plans

Option	☐ NJ P MTRO NG 10/40/100 EPO 21 2	☐ NJ P MTRO GT 5/75/100 EPO 21	☐ NJ P MTRO NG 10/40/100 EPO 21 1
Network	Metro	Metro	Metro
Gated/Non-Gated	N	Y	N
Copayment			
a. PCP	$10	$5	$10
b. Specialist	$40	$75	$40
In-Network Deductible (Single)	N/A	N/A	N/A
In-Network Deductible (Family)	N/A	N/A	N/A
In-Network Maximum Out of Pocket (Single)	$3,500	$3,500	$2,500
In-Network Maximum Out of Pocket (Family)	$7,000	$7,000	$5,000
In-Network Coinsurance	N/A	N/A	N/A
Outpatient Facility			
Freestanding	$10	$10	$50
Hospital	$500	50%	$150
Inpatient Facility	$200 per day up to $400 per admit	$500 per day up to $2,500 per admit	$200 per day up to $400 per admit
Emergency Room	$100	50%	$100
Out of Network Deductible (Single)	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A
Prescription Drug	Tier 1 - $5 Tier 2 - $35* Tier 3 - $60* Mail order = 2x copayment *After $100 RX deductible	Tier 1 - $5 Tier 2 - $25* Tier 3 - $60* Mail order = 2x copayment *After $100 RX deductible	Tier 1 - $5 Tier 2 - $35* Tier 3 - $60* Mail order = 2x copayment *After $100 RX deductible

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

Additional Benefit Options:
☐ **Domestic Partner**

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

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F. Metro Gold Plans

Option	☐ NJ G MTRO NG 2000/100 EPO HSA 21	☐ NJ G MTRO NG 25/50/1000/50 EPO 21	☐ NJ G MTRO NG 25/60/1500/80 EPO 21 1
Network	Metro	Metro	Metro
Gated/Non-Gated	N	N	N
Copayment			
a. PCP	No Charge after ded	$25	$25
b. Specialist	No Charge after ded	$50	$60
In-Network Deductible (Single)	$2,000	$1,000	$1,500
In-Network Deductible (Family)	$4,000	$2,000	$3,000
In-Network Maximum Out of Pocket (Single)	$6,000	$5,000	$5,000
In-Network Maximum Out of Pocket (Family)	$12,000	$10,000	$10,000
In-Network Coinsurance	N/A	50%	20%
Outpatient Facility			
Freestanding	No Charge after ded	$100	$100
Hospital	No Charge after ded	50% after ded	50% after ded
Inpatient Facility	No Charge after ded	50% after ded	20% after ded
Emergency Room	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A
Prescription Drug	Tier 1 - $10* Tier 2 - $40* Tier 3 - $50%* Mail order = 2x copayment *After medical deductible	Tier 1 - $10 Tier 2 - $40* Tier 3 - $50%* Mail order = 2x copayment *After $100 Rx deductible	Tier 1 - $10 Tier 2 - $40* Tier 3 - $50%* Mail order = 2x copayment *After $100 Rx deductible

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F. Metro Gold Plans (continued)

Option	☐ NJ G MTRO NG 30/60/2000/70 EPO 21 2	☐ NJ G MTRO GT 5/75/2000/50 EPO 21	☐ NJ G MTRO NG 30/60/2000/70 EPO 21 1
Network	Metro	Metro	Metro
Gated/Non-Gated	N	Y	N
Copayment			
a. PCP	$30	$5	$30
b. Specialist	$60	$75	$60
In-Network Deductible (Single)	$2,000	$2,000	$2,000
In-Network Deductible (Family)	$4,000	$4,000	$4,000
In-Network Maximum Out of Pocket (Single)	$7,000	$8,000	$6,850
In-Network Maximum Out of Pocket (Family)	$14,000	$16,000	$13,700
In-Network Coinsurance	30%	50%	30%
Outpatient Facility			
Freestanding	30% after ded	$500	30% after ded
Hospital	30% after ded	$500 after ded	30% after ded
Inpatient Facility	30% after ded	50% after ded	$500 per admit up to $5,000 per year
Emergency Room	$100 then 50% after ded	50% after ded	$100 then 30% after ded
Out of Network Deductible (Single)	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A
Prescription Drug	Tier 1 - $10 Tier 2 - $40* Tier 3 - $50%* Mail order = 2x copayment *After $100 Rx deductible	Tier 1 - $5 Tier 2 - $25* Tier 3 - $60* Mail order = 2x copayment *After $100 Rx deductible	Tier 1 - $15 Tier 2 - $35 Tier 3 - $75 Mail order = 2x copayment

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F. Metro Gold Plans (continued)

Option	☐ NJ G MTRO NG 25/60/1500/80 EPO 21 2	☐ NJ G MTRO NG 25/50/750/50 EPO 21	☐ NJ G MTRO NG 1700/100 EPO HSA 21
Network	Metro	Metro	Metro
Gated/Non-Gated	N	N	N
Copayment			
a. PCP	$25	$25	No Charge after ded
b. Specialist	$60	$50	No Charge after ded
In-Network Deductible (Single)	$1,500	$750	$1,700
In-Network Deductible (Family)	$3,000	$1,500	$3,400
In-Network Maximum Out of Pocket (Single)	$5,000	$5,500	$4,000
In-Network Maximum Out of Pocket (Family)	$10,000	$11,000	$8,000
In-Network Coinsurance	20%	50%	N/A
Outpatient Facility			
Freestanding	$100	$100	No Charge after ded
Hospital	50% after ded	50% after ded	No Charge after ded
Inpatient Facility	20% after ded	50% after ded	No Charge after ded
Emergency Room	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A
Prescription Drug	Tier 1 - $10 Tier 2 - $40* Tier 3 - $70* Mail order = 2x copayment *After $100 Rx deductible	Tier 1 - $10 Tier 2 - $40* Tier 3 - $70* Mail order = 2x copayment *After $100 Rx deductible	Tier 1 - $10* Tier 2 - $40* Tier 3 - $70* Mail order = 2x copayment *After medical deductible

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

Additional Benefit Options:
☐ Domestic Partner

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

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G. Metro Silver Plans

Option	☐ NJ S MTRO NG 40/75/2500/50 EPO 21 2	☐ NJ S MTRO NG 50/75/2500/60 EPO 21	☐ NJ S MTRO NG 25/50/2000/80 EPO HSA 21 2
Network	Metro	Metro	Metro
Gated/Non-Gated	N	N	N
Copayment			
a. PCP	$40	$50	$25 after ded
b. Specialist	$75	$75	$50 after ded
In-Network Deductible (Single)	$2,500	$2,500	$2,000
In-Network Deductible (Family)	$5,000	$5,000	$4,000
In-Network Maximum Out of Pocket (Single)	$8,550	$8,550	$7,000
In-Network Maximum Out of Pocket (Family)	$17,100	$17,100	$14,000
In-Network Coinsurance	50%	40%	20%
Outpatient Facility			
Freestanding	$250 after ded	$250 after ded	$250 after ded
Hospital	50% after ded	50% after ded	$500 after ded
Inpatient Facility	50% after ded	40% after ded	$500 per admit after ded
Emergency Room	$100 then 50% after ded	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	N/A	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A	N/A
Out of Network Coinsurance	N/A	N/A	N/A
Prescription Drug	Tier 1 - $5 Tier 2 - $50* Tier 3 - 50%* Mail order = 2x copayment *After $100 Rx deductible	Tier 1 - $5 Tier 2 - $50* Tier 3 - 50%* Mail order = 2x copayment *After $100 Rx deductible	Tier 1 - $5* Tier 2 - $50* Tier 3 - 50% to $150* Mail order = 2x copayment *After medical deductible

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G. Metro Silver Plans (continued)

Option	☐ NJ S MTRO NG 40/75/2500/50 EPO 21 1	☐ NJ S MTRO NG 25/50/2000/80 EPO HSA 21 1
Network	Metro	Metro
Gated/Non-Gated	N	N
Copayment		
a. PCP	$40	$25 after ded
b. Specialist	$75	$50 after ded
In-Network Deductible (Single)	$2,500	$2,000
In-Network Deductible (Family)	$5,000	$4,000
In-Network Maximum Out of Pocket (Single)	$8,150	$6,550
In-Network Maximum Out of Pocket (Family)	$16,300	$13,100
In-Network Coinsurance	50%	20%
Outpatient Facility		
Freestanding	$250	$75 after ded
Hospital	$500	$500 after ded
Inpatient Facility	$500 per admit up to $5,000 per year	$500 per admit after ded up to $5,000 per year
Emergency Room	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A
Out of Network Coinsurance	N/A	N/A
Prescription Drug	Tier 1 - $10 Tier 2 - $40* Tier 3 - $70* Mail order = 2x copayment *After $100 Rx deductible	Tier 1 - $10* Tier 2 - $40* Tier 3 - $70* Mail order = 2x copayment *After medical deductible

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

Additional Benefit Options:
☐ **Domestic Partner**

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

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H. Metro Bronze Plans

Option	☐ NJ B MTRO NG 5900/50 EPO HSA 21	☐ NJ B MTRO NG 10/70/6000/50 EPO HSA 21
Network	Metro	Metro
Gated/Non-Gated	N	N
Copayment		
a. PCP	50% after ded	$10 after ded
b. Specialist	50% after ded	$70 after ded
In-Network Deductible (Single)	$5,900	$6,000
In-Network Deductible (Family)	$11,800	$12,000
Emergency Room	$100 then 50% after ded	$100 then 50% after ded
Out of Network Deductible (Single)	N/A	N/A
Out of Network Deductible (Family)	N/A	N/A
Out of Network Maximum Out of Pocket (Single)	N/A	N/A
Out of Network Maximum Out of Pocket (Family)	N/A	N/A
Out of Network Coinsurance	N/A	N/A
Prescription Drug	Tier 1 - 50%* Tier 2 - 50%* Tier 3 - 50%* *After medical deductible	Tier 1 - 50%* Tier 2 - 50%* Tier 3 - 50%* *After medical deductible

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

Additional Benefit Options:
☐ **Domestic Partner**

Contraceptives ☐ Yes (Standard) ☐ No (Qualified State-Exempt Groups Only)

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III. All questions must be answered

1. Is there any Group Health Plan:
   Now in force and to be continued? ☐ Yes ☐ No
   Currently being applied for? ☐ Yes ☐ No

   If "yes," identify the name of the Group Health Plan, give a description of the plan(s) and the name of insurance carrier(s):

   ____

2. Name of present or prior group carrier: ______________________________

   Effective date of prior coverage:__________________ Cancellation/termination date:__________________

   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No

   If "yes," give reason: ______________________________

   Plan being replaced: ______________________________

3. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

4. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

   Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/ Federal/Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start End

   If additional space is needed, attach a separate sheet, signed and dated.

5. To the best of your knowledge:
   A. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   B. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

   Additional space to explain if Items 1, 2 or 3 were answered "yes." Refer to the question number, and give details including names, where appropriate.

   ____

   ____

   ____

6. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No

   (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

IV. Agent/producer information

Broker ______________________________ ______________________________
Name Code Address

Broker ______________________________ ______________________________
Name Code Address

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V. Signature

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. (Refer to the definition on the New Jersey Employer Certification.) It is further understood that no agent has power on behalf of Oxford to make or modify any request or application for insurance or to bind Oxford by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Oxford. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at:____on______________________

______________________________________ ______________________________________

Print name of Officer, Partner or Proprietor | Signature of Officer, Partner or Proprietor

____

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

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