UnitedHealthcare®
Oxford

Freedom Plan® Classic℠
Liberty Plan℠ Classic
Freedom Plan® Access℠
Liberty Plan℠ Access
Oxford Exclusive Plan℠
-(Freedom, Liberty & Metro)
Primary Advantage
-(Freedom, Liberty & Metro)

Oxford® HSA Exclusive℠
Freedom Plan® Direct℠
Liberty Plan℠ Direct
Oxford MyPlan℠
Oxford® HSA Direct℠
Oxford Ease℠
-(Freedom & Liberty)

New York Large Group Application – OHI

Oxford Health Insurance Inc.

Corporate 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)

3. **Plan Administrator/Contact:**
   a. Name
   b. Title
   c. Address
      (If it differs from address of firm)
   d. Phone Number
      Area Code
   e. Email Address

4. **Plan year end date:**
   (for purpose of maintaining plan's fiscal records)

5. **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

6. **Full legal name of each subsidiary and/or affiliated company whose employees are to be covered:**

7. **Nature of Business:**

8. **Tax ID Number:**

9. **SIC Code:**

I. GENERAL INFORMATION (CONTINUED)

10. Type of Organization: ❒ Corporation ❒ Partnership ❒ LLC ❒ LLP ❒ Other _____
Did you have any employees other than yourself and your spouse during the preceding calendar year? ❒ Yes ❒ No

11. Enter the Prior Calendar Year Full-time Equivalent Total Number of Employees _____
(This information will be used to determine whether you are a small group.)

For purposes of determining your number of full-time equivalent employee count, please use the following calculation:

(1) For each month during the calendar year, count all full-time employees. (A full-time employee is one who works an average of 30 or more hours per week.)
(2) For each month during the calendar year, count all HOURS worked by part-time employees and divide by 120.
(3) Add the number resulting from (2) to the number resulting from (1) for each month during calendar year.
   a) Only if the total number is equal to or exceeds 101 employees, then you must verify that "seasonal workers" who worked less than 120 days were not included and remove them from the calculation.
   b) A "seasonal worker" is one who performs labor or services on a seasonal basis as defined by the Federal Secretary of Labor, including retail workers employed only during a holiday season.
(4) Divide the total number of (3) by 12. If the business was new and did not operate for all of the previous calendar year, divide by the number of months of data that were used.

12. Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees _____
(This question is included for Department of Health and Human Services reporting purposes only and does not determine group size.)

Under Health Care Reform law, the average total number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is any person whose work is controlled and directed by the employer (also known as common law employees). Employees may work full-time, part-time and on a seasonal basis. Individuals do not have to qualify for medical coverage to be considered employees. Although employees generally will receive a W-2, include in your employee count common law employees who may not always get W-2s.

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

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

14. 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)
❒ Multiple Employer Welfare Arrangement (MEWA)
❒ Taft Hartley Union
❒ Governmental
❒ Church
❒ Employer Association

15. 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 UnitedHealthcare will not cover the coemployees under this group policy.

16. 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

17. 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.

I. GENERAL INFORMATION (CONTINUED)

18. 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 on page2).

___ 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.

1. **Effective date:** We request that this coverage be effective as of the first day of _____. (Month/Year)
2. **Anniversary date:** The anniversary date is the first day of the calendar month which is shown in the effective date.
3. **Other group health or HMO coverage:** Indicate below other group health coverage which is still in force or which terminated within the past three years.

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

4. **Contribution basis:**

Benefit	**Employer contribution percentage***
Employee: Health	_____ %
Family: Health	_____ %

*There is no minimum employer contribution.

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 on the date the Certificate becomes effective, the employee must wait until the next day on which he/she is eligible to begin coverage.

a) **Employee Eligibility:**

Eligible Employees: All permanent, full-time employees who work at least _____ hours per week (minimum of 30 hours/week).

Are any classes excluded? ❑ Yes ❑ No

If yes, indicate classes excluded:_____

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.

II. ADMINISTRATIVE INFORMATION (CONTINUED)

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

*Indicate number of months or days, whichever is applicable, in the space provided below. In (i) below, if there is no waiting period, insert "O" in the space provided for the number of days or months of continuous service. In (ii) below, indicate whether eligibility is the 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. Waiting period cannot be longer than 90 days.

CLASS I

Definition of Class I _____

_____

i) Eligibility

❑ Date on which the employee completes:

*_____ months 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:

*_____ months of continuous service, or

*_____ days of continuous service

Termination

❑ On the last day of the calendar month in which employee's service terminates.

CLASS II

Definition of Class II _____

_____

i) Eligibility

❑ Date on which the employee completes:

*_____ months 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:

*_____ months of continuous service, or

*_____ days of continuous service

Termination

❑ On the last day of the calendar month in which employee's service terminates.

6. **Number of Employees Eligible on Effective Date:** Current Eligible 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 covered by Medicare Part A and B are carved out 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 26, and who is chiefly dependent upon the employee for support.

   The term "child" means the employee's children, including any legal stepchild, adopted child, or child for whom the employee or employee's spouse is the court-appointed legal guardian. A prospective adopted child is eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.

   If a child cannot support himself/herself due to mental retardation 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 as specified in the Group Certificate.

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

III. PRODUCT/PLAN DESIGN

A. Freedom Plan Access, Liberty Plan Access, Freedom Plan Classic, Liberty Plan Classic, Oxford Exclusive Plan – Freedom, Oxford Exclusive Plan – Liberty, Oxford Exclusive Plan - Metro, Oxford Ease – Freedom, Oxford Ease – Liberty, Oxford HSA Exclusive*, Primary Advantage – Freedom, Primary Advantage – Liberty, Primary Advantage - Metro

1. **Funding Method:** ❑ Fully Insured ❑ Self Insured
2. **Conversion Status:** ❑ Full Conversion ❑ Offering
3. **Network/Product:**
   - ❑ Freedom Plan Classic[A]
   - ❑ Freedom Plan Access[A]
   - ❑ Liberty Plan Classic[B]
   - ❑ Liberty Plan Access[B]
   - ❑ Oxford Ease – Freedom
   - ❑ Oxford Exclusive Plan – Freedom[1]
   - ❑ Oxford HSA Exclusive – Freedom Only[1]
   - ❑ Oxford Ease – Liberty
   - ❑ Oxford Exclusive Plan – Liberty[1]
   - ❑ Primary Advantage – Freedom
   - ❑ Oxford Exclusive Plan – Metro[1]
   - ❑ Oxford HSA Exclusive– Metro[1]
   - ❑ Primary Advantage – Liberty
   - ❑ Primary Advantage – Metro

4. Please complete section below:

Office copayment _____
Deductible * * _____
Coinsurance (%) _____
Maximum Out-of-Pocket _____
[A]Out-of-Network Reimbursement Freedom:
UCR fee schedule[2] or _____
Medicare Rate[3] _____
[B]Out-of-Network Reimbursement Liberty: based upon 140% of Medicare Rate[3]

5. Please check supplemental coverage(s) selected:

Prescription Plan: (Required for HSA)
Copayment Tier 1 Drugs _____
Copayment Tier 2 Drugs _____
Copayment Tier 3 Drugs _____
Prescription Deductible (if applicable) _____

❑ Contraceptives
- ❑ Yes (Standard)
- ❑ No (Qualified State Exempt groups only)

* *__NOTE:__ For Oxford HSA Exclusive, all in-network medical and pharmacy services are subject to the in-network deductible. Once the deductible has been satisfied, the applicable medical coinsurance, medical copays and prescription drug copays will apply based on the option selected at plan inception. Out-of-network benefits are accumulated separately.

Deductibles and out-of-pocket accumulation periods are on a: ❑ calendar year basis ❑ contract year basis[1]

6. Additional benefit options:

- ❑ Domestic Partner
- ❑ Successor Subscriber and Alternate Subscriber
- ❑ Advanced Infertility _____
- ❑ Waive Advanced Infertility
- Physical Therapy
  - ❑ 100 visits per calendar year
  - ❑ 90 visits per calendar year
- ❑ Mandated Offering – Dependent Age Extension through 29

Medicare Part D 28% Subsidy – For the Prescription plan design above, do you currently participate or plan to participate with the 28% Government Subsidy for your Medicare eligible retirees?

❑ Yes ❑ No

- ❑ Alternative Medicine
- ❑ Emergency Room _____
- ❑ Skilled Nursing Facility _____
- ❑ SimplyEngaged® _____

❑ Hospital Copayment
- Inpatient _____
- Outpatient _____

Other: _____

Note: If more than one product/plan design has been selected, please attach a photocopy of this selection to your application.
*Groups enrolling in the Oxford HSA Exclusive Plan must also fill out an Oxford HSA Bank Notification Form (#7423).

B. Freedom Plan Direct & Liberty Plan Direct

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)[A]**
   ❑ **Freedom Plan Direct (Deductible & Coinsurance only)[A]**
   ❑ **Liberty Plan Direct (Office Visit Copayment)[B]**
   ❑ **Liberty Plan Direct (Deductible & Coinsurance only)[B]**

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

Office Visit Copayment: _____

In-network

Deductible: _____

Coinsurance: _____

Maximum Out-of-Pocket: _____

III. PRODUCT/PLAN DESIGN (CONTINUED)

Out-of-network

Deductible: _____

Coinsurance: _____

Maximum Out-of-Pocket: _____

[A]Out-of-Network Reimbursement Freedom: _____UCR fee schedule[2] or _____Medicare Rate[3]
[B]Out-of-Network Reimbursement Liberty: based upon 140% of Medicare Rate[3]

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 Contraceptives ❑ Yes (Standard) ❑ No (Qualified State Exempt groups only)

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

❑ Mandated Offering – Dependent Age Extension through 29
❑ Domestic Partner
❑ SimplyEngaged®

Skilled Nursing Facility
❑ 180 days per calendar year
❑ 200 days per calendar year
❑ Unlimited

Physical Therapy: ❑ 90 visits per calendar year ❑ 100 visits per calendar year

❑ Other (please specify): _____

_____

C. Oxford MyPlan

Please Note: Groups enrolling in the Oxford MyPlan must also fill out an Oxford MyPlan Health Reserve Account Group Application Form (#6740). No referrals are required for these plans designs.

1. Please select network: ❑ Freedom[A] ❑ Liberty[B]

2. Please complete section below (if applicable):

In-network

Deductible: _____

Coinsurance: _____

Maximum Out-of-Pocket: _____

III. PRODUCT/PLAN DESIGN (CONTINUED)

Out-of-network

Deductible: _____

Coinsurance: _____

Maximum Out-of-Pocket: _____

[A]Out-of-Network Reimbursement Freedom: _____UCR fee schedule[2] or _____Medicare Rate[3]

[B]Out-of-Network Reimbursement Liberty: based upon 140% of Medicare Rate[3]

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

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

4. Additional Benefit Options: ❑ Mandated Offering – Dependent Age Extension through 29
❑ Domestic Partner
❑ SimplyEngaged®

❑ Other (please specify): _____

_____

D. Oxford HSA Direct

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

No referrals are required for these plan designs.

1. Please select network:

❑ Freedom[A] ❑ Liberty[B]

2. Please complete section below (if applicable):

Office Visit Copayment: _____

III. PRODUCT/PLAN DESIGN (CONTINUED)

In-network

Deductible: * *_____

Coinsurance: _____

Maximum Out-of-Pocket: _____

Out-of-network

Deductible: _____

Coinsurance: _____

Maximum Out-of-Pocket: _____

[A]Out-of-Network Reimbursement Freedom:
UCR fee schedule[2] or _____
Medicare Rate[3] _____

[B]Out-of-Network Reimbursement Liberty:

❑ UCR fee schedule 80th percentile or

❑ Medicare Rate 140%

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

Prescription Drug Plan (Required)* *

Copayment Information_____

Tier 1 _____ Tier 2 _____ Tier 3 _____

Mail-Order Prescription Drug Plan: ❑ Yes ❑ No Contraceptives ❑ Yes (Standard) ❑ No (Qualified State Exempt groups only)

* ***NOTE:*** All in-network medical and pharmacy services are subject to the in-network deductible. Once the deductible has been satisfied, the applicable medical coinsurance and copayments, and prescription drug copayments will apply based on the option selected at plan inception. Out-of-network benefits are accumulated separately.

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

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

❑ Domestic Partner

❑ Mandated Offering – Dependent Age Extension through 29

❑ SimplyEngaged®

Skilled Nursing Facility

❑ 180 days per calendar year

❑ 200 days per calendar year

❑ Unlimited

Physical Therapy: ❑ Outpatient (90 visits per calendar year) ❑ Long-term (100 visits per calendar year)

❑ Other (please specify): _____

_____

IV. BROKER/AGENT INFORMATION

	Broker	Co-Broker	General Agent
1. Name of Payee:			
2. Payee's Oxford Broker Code (Required):			
3. Payee's Social Security # or Federal Tax ID # :			
4. Name of Writing Agent (Required if Payee is a company):			
5. Writing Agent's Oxford Broker Code (Required if Payee is a company):			
6. Commission Split % :			
7. Sales Representative:			
Comments:			

***Important Information Regarding Producer Compensation:**
We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also may make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant). Producer compensation is subject to disclosure of Schedule A of the ERISA Form 5500 for customers governed by ERISA and subject to form 5500 filing requirements. We have also taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, please go to **www.oxfordhealth.com**. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

V. CONSENT

AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

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

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

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

_____ Remain in place until _____.
(Date)

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

VI. COBRA & EXTENSION OF BENEFITS DATA

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? _____

VII. 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

VIII. 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.

Dated at:_____this_____day of_____20_____.

Full legal name of firm:

The above named company confirms that we employ at least 101 full-time equivalent employees.

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

Oxford Health Insurance, Inc.

X

Signature of Authorized Officer of the Company | Title

Witness | Duly Licensed Resident Agent/Broker

[2]The Standard, High and Very High UCR 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 a FAIR Health, Inc. We use 70th percentile data for the standard UCR fee schedule, 80th percentile data for the high UCR fee schedule, and 90th percentile data for the very-high UCR 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.

[3]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.