Since 1948

Centurion Agency Ltd.

Complete Insurance & Financial Services

Oxford Enrollment Guidelines

New York – PPO/EPO Small Group (2+)

All New cases must have the following:

1. Group Application – completed and signed by the employer & agent.
2. Enrollment Application for each employee.
3. Waiver Form for each non-enrolling eligible employee.
4. Employer Affirmation Letter – completed and signed.
5. Proof of Prior Coverage (Copy of Previous Months Bill).
6. Business Check payable to: **Oxford** for the 1st month's premium. Oxford will only accept business checks or start-up checks from the group. A letter must accompany start-up checks from the bank stating that they are a new business account and that checks are being printed. Oxford will then expect all future premiums to be paid with a business check. Money orders, personal checks, certified checks or checks from the broker are not accepted.
7. NYS-45 (tax document), most recent. (showing employee names and salaries)
8. Copy of the proposal showing both plan rates and benefits chosen.

Note: Effective dates can only be the 1st or the 15th of the month. We must receive all completed material at least 6 business days prior to the requested effective date.

www.lifeandhealth.biz
centurionagencyltd.com

A Full Service Brokerage General Agency

Life/Long Term Care/Group Benefits/Disability Income/Annuities/Health

516-561-0100 * Fax: 516-825-0953

65 Roosevelt Ave., Ste. 106A, Box 1147, Valley Stream NY 11582-1147

UnitedHealthcare®
Oxford

Freedom Plan® PPO
Liberty Plan PPO
Liberty Plan℠ Gated PPO
Oxford® PPO HSA
Oxford® EPO
Liberty Plan℠ Gated EPO
Oxford® EPO HSA
Primary Advantage℠

New York Small Group Application – OHI

Oxford Health Insurance Inc. ▪ www.oxfordhealth.com
Mailing Address: Group Enrollment Department, 14 Central Park Drive, Hooksett, NH 03106

I. GENERAL INFORMATION

1. **Full Legal Name of Group:**
2. **Primary Address of Group:**
   (Street Address
   City, State, ZIP Code)
   No P.O. Box
3. **Plan Administrator/Contact:**
   a. Name
   b. Title
   c. Address
   (If different from primary)
   City, State, ZIP code
   d. Phone Number Ext.
   e. Fax Number
   f. Email Address
   g. Add'l Contact & Number
4. **Name and title of person to receive billing statements:**
   a. Name
   b. Title
   c. Address
   (If different from primary)
   City, State, ZIP code
   d. Phone Number Ext.
   e. Fax Number
5. **Full legal name of each subsidiary and/or affiliated company whose employees are to be covered (if applicable):**
6. **Nature of Business:**
7. **SIC Code:**
8. **Tax Identification Number:**

II. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate of Coverage. To be eligible for small group coverage, you must be located in a county where we offer this Oxford product and have at least 1 but not more than 100 eligible employees.

1. Effective date: We request that this coverage be effective _____.
2. Anniversary date: The anniversary date is the first day of the calendar month that is closest to the effective date.
3. Open enrollment period: The open enrollment period is the month prior to your anniversary date. The open enrollment effective date is the first of the month following the period.
4. 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.
5. Enter the Prior Calendar Year Average 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).
6. How many eligible employees does this group have? _____
   Eligible employees: Active permanent employees of the employer and of all subsidiaries or affiliates of a corporate employer who work **20 or more** hours per week and are eligible for health benefits through the employer's group health plan. Eligible employees do not include:
   - any person who does not meet the common law employee definition under Department of Labor and Internal Revenue Code rules or
   - any former employee who is covered through retiree benefits, COBRA or state continuation.

   An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours and occupational duties. Employees who work less than 20 hours per week are not eligible employees and may not enroll in any Oxford products. If coverage is limited to specific class(es) of employees, the classes must be specified in response to question 20 below.

   If the employer does not offer group health coverage to all eligible employees, eligible employees should include (1) the number of eligible employees who work in the state of New York and (2) if the employer offers Oxford coverage to out-of-state employees, the number of out-of-state eligible employees.
7. Total number of employees being offered coverage through this product: _____
   Of the eligible employees who work 20 or more hours per week, please list all employees who will be offered coverage under this policy. If coverage is limited to specific class(es) of employees, the classes must be specified in response to question 20 below.

   Groups seeking to purchase insurance, rather than HMO coverage, also must meet the minimum participation requirements for coverage, except during the annual open enrollment period from November 15th - December 15th. Please see our underwriting guidelines for details on our minimum participation requirements.
8. If the employer offers retiree coverage, how many eligible retired former employees does this group have? _____
   Integration with Medicare benefits: Health benefits covered by Medicare Part A and B are carved out for retired employees aged 65 or over and their dependents aged 65 or over, if the group offers retiree coverage.
9. Total number of employees and former employees enrolling: _____
   Enrolling means the total number of eligible employees, COBRA or state continuation enrollees, and retired employees (if applicable) accepting coverage with any Oxford product.
   a. of those former employees enrolling, how many are retired? _____
   b. of those former employees enrolling, how many are enrolling through COBRA or state continuation? _____

II. ADMINISTRATIVE INFORMATION (CONTINUED)

10. Total number of employees waiving coverage for the following reasons (for non-HMO coverage only):
    a. A spouse's health benefit plan: _____
    b. Medicare: _____
    c. Medicaid: _____
    d. Veteran's coverage: _____
    e. All other waivers (include number of eligible employees enrolling in other employer-sponsored HMO or insurance coverage): _____
11. Total number of valid waivers (for non-HMO coverage only) (a – d): _____
12. Is the Employer offering other group health insurance coverage to employees who are eligible for coverage in an Oxford product? (check no if group only offers other HMO coverage) ❒ Yes ❒ No

    Please list other current or past group health or HMO coverage offered by Employer in the last three years:

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

13. Is your group subject to COBRA (20 or more total employees during at least 50% of the working days in the previous calendar year)? ❒ Yes ❒ No
14. 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 _____
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)
    ❒ Multiple Employer Welfare Arrangement (MEWA)
    ❒ Taft Hartley Union
    ❒ Governmental
    ❒ Church
    ❒ 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
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.
19. Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage), and if so, for how long once an employee begins a leave of absence? (Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)
    ❒ Last Day worked (following the last day worked for the minimum hours required to be eligible)
    ❒ 3 Months (following the last day worked for the minimum hours required to be eligible)
    ❒ 6 Months (following the last day worked for the minimum hours required to be eligible)
    ❒ No, we do not offer medical coverage during a leave of absence

    If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for:
    (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence.
    (2) No longer than 6 consecutive months if the employee is totally disabled.
    If this coverage terminates, 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.
    The Employer's decision to refuse to offer coverage cannot be based upon health status related factors.

II. ADMINISTRATIVE INFORMATION (CONTINUED)

20. Eligible employee class(es), Waiting period and Termination:

If coverage is being limited to particular class(es) of employees, please specify class definition(s) below. An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours, and occupational duties. Although an Employer may establish a class of employees who work less than 20 hours per week, Oxford products are not available to employees who work less than 20 hours per week.

We do not have waiting periods for new employees. Employers may set a waiting period for new employees from 0 to 90 days. A newly eligible employee has 30 days to enroll from the first day of eligibility.

If classes and waiting periods are not specified below, all eligible employees who work 20 or more hours per week will be eligible for group health benefits under an Oxford policy without a waiting period.

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).

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**
Maximum Waiting Period is 90 days

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**
Maximum Waiting Period is 90 days

Waiting Period waived for Rehires? ❒ Yes ❒ No
If yes, waived if rehired within _____ months.

III. PRODUCT AND PLAN DESIGNS

A. Platinum Plans

Option	❑ Oxford EPO (Platinum) 5/15	❑ Oxford EPO (Platinum) 20/40
Network	Freedom	Freedom
Copayment: **a. PCP** **b. Specialist**	 $5 per visit $15 per visit	 $20 per visit $40 per visit
In-Network Deductible (Single/Family)	N/A	N/A
In-Network Maximum Out-of-Pocket (Single/Family)	$3,000/$6,000	$3,000/$6,000
In-Network Coinsurance	N/A	N/A
Outpatient Facility Copayment	Freestanding Facility – $50 Hospital Facility – $100	Freestanding Facility – $100 Hospital Facility – $300
Inpatient Facility Copayment	$150 per admission	$500 per admission
Emergency Room	$100	$200
Prescription Drug Coverage	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible**– $100	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible**– $100

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Platinum Plans (Continued)

Option	❑ Oxford PPO (Platinum) 5/15	❑ Oxford PPO (Platinum) 20/40 MNRP	❑ Oxford PPO (Platinum) 20/40 FAIR
Network	Freedom	Freedom	Freedom
Copayment: **a. PCP** **b. Specialist**	 $5 per visit $15 per visit	 $20 per visit $40 per visit	 $20 per visit $40 per visit
In-Network Deductible (Single/Family)	N/A	N/A	N/A
In-Network Maximum Out-of-Pocket (Single/Family)	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000
In-Network Coinsurance	N/A	N/A	N/A
Outpatient Facility Copayment	Freestanding Facility – $50 Hospital Facility – $100	Freestanding Facility – $100 Hospital Facility – $300	Freestanding Facility – $100 Hospital Facility – $300
Inpatient Facility Copayment	$150 per admission	$500 per admission	$500 per admission
Emergency Room	$100	$200	$200
Out-of-Network Deductible (Single/Family)	$2,000/$4,000	$3,000/$6,000	$3,000/$6,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	$5,000/$10,000	$7,500/$15,000	$7,500/$15,000
Out-of-Network Coinsurance	30%	30%	20%
Out-of-Network Reimbursement	140% MNRP	140% MNRP	80% FAIR***
Prescription Drug Coverage	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible**– $100	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible**– $100	Tier 1 – $5 copayment Tier 2 – $30 copayment Tier 3 – $60 copayment Mail-Order – 2.5x copay Deductible**– $100

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year ❑ contract year basis.
**Deductible applies to Tier 2 and Tier 3 drugs.
*** Deductible and out-of-pocket accumulation period for the plan are on a contract year basis

Additional Benefit Options:
❑ Domestic Partner
❑ Mandated Offering – Dependent Age Extension to 29

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

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

B. Gold Plans

Option	❑ Oxford EPO (Gold) 15/30	❑ Oxford EPO (Gold) 25/40
Network	❑ Freedom ❑ Liberty	❑ Freedom ❑ Liberty
Copayment: **a. PCP** **b. Specialist**	 $15 per visit $30 per visit	 $25 per visit $40 per visit
In-Network Deductible (Single/Family)	$800/$1,600	$1,250/$2,500
In-Network Maximum Out-of-Pocket (Single/Family)	$4,000/$8,000	$5,000/$10,000
In-Network Coinsurance	10%	20%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250
Inpatient Facility Copayment	10% after Deductible has been met	20% after Deductible has been met
Emergency Room	$300	$300
Prescription Drug Coverage	Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100	Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Gold Plans (Continued)

Option	❑ Oxford EPO HSA (Gold) $1500***	❑ Oxford EPO (Gold) 50	❑ Liberty Plan Gated* EPO (Gold) 30/60
Network	Freedom	Freedom	Liberty
Copayment: **a. PCP** **b. Specialist**	10% after Deductible has been met 10% after Deductible has been met	$50 per visit $50 per visit	$30 per visit $60 per visit
In-Network Deductible (Single/Family)	$1,500/$3,000	$750/$1,500	$1,000/$2,000
In-Network Maximum Out-of-Pocket (Single/Family)	$2,000/$4,000	$4,000/$8,000	$4,000/$8,000
In-Network Coinsurance	10%	10%	N/A
Outpatient Facility Copayment	10% after Deductible has been met	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250
Inpatient Facility Copayment	10% after Deductible has been met	Deductible then $250 per day to $2,500 maximum per year	Deductible then $500 per day to $2,000 maximum per admission
Emergency Room	10% after Deductible has been met	$300	$200
Prescription Drug Coverage	Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***	Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Gold Plans (Continued)

Option	❑ Oxford PPO (Gold) 25/40	❑ Oxford PPO HSA (Gold) $1500***
Network	Freedom	Freedom
Copayment: **a. PCP** **b. Specialist**	 $25 per visit $40 per visit	 10% after Deductible has been met 10% after Deductible has been met
In-Network Deductible (Single/Family)	$1,000/$2,000	$1,500/$3,000
In-Network Maximum Out-of-Pocket (Single/Family)	$4,000/$8,000	$2,000/$4,000
In-Network Coinsurance	20%	10%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250	10% after Deductible has been met
Inpatient Facility Copayment	20% after Deductible has been met	10% after Deductible has been met
Emergency Room	$300	10% after Deductible has been met
Out-of-Network Deductible (Single/Family)	$3,000/$6,000	$3,000/$6,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	$7,500/$15,000	$7,500/$15,000
Out-of-Network Coinsurance	40%	40%
Prescription Drug Coverage	Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100	Tier 1 – $10 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year ❑ contract year basis.
*Referrals are required for this plan design.
**Deductible applies to Tier 2 and Tier 3 drugs.
***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. No individual on a multiple-person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket has been met.

Additional Benefit Options:
❑ Domestic Partner
❑ Mandated Offering – Dependent Age Extension to 29

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

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

C. Silver Plans

Option	❑ Liberty Plan EPO (Silver) 30/75	❑ Primary Advantage (Silver) $1500 25/50***	❑ Oxford EPO HSA (Silver) $2000***
Network	Liberty	Liberty	Freedom
Copayment: **a. PCP** **b. Specialist**	$30 per visit $75 per visit	$25 per visit Deductible then $50 per visit	30% after Deductible has been met 30% after Deductible has been met
In-Network Deductible (Single/Family)	$3,000/$6,000	$1,500/$3,000	$2,000/$4,000
In-Network Maximum Out-of-Pocket (Single/Family)	$6,600/$13,200	$5,500/$11,000	$6,400/$12,800
In-Network Coinsurance	40%	30%	30%
Outpatient Facility Copayment	40% after Deductible has been met	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250	30% after Deductible has been met
Inpatient Facility Copayment	40% after Deductible has been met	Deductible then $250 per day to a maximum of $1,250 per admission	30% after Deductible has been met
Emergency Room	Deductible then $500	30% after Deductible has been met	30% after Deductible has been met
Prescription Drug Coverage	Tier 1 – $15 copayment Tier 2 – $65 copayment Tier 3 – 50% copayment to $800 maximum Mail-Order – 2.5x copay Deductible** – $100	Tier 1 – $15 copayment Tier 2 – Deductible then $35 copayment Tier 3 – Deductible then $75 copayment Mail-Order – 2.5x copay Deductible**	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Silver Plans (Continued)

Option	❑ Oxford EPO HSA (Silver) $2000 25/50***	❑ Oxford EPO (Silver) 40/70	❑ Oxford Gated* EPO (Silver) 25/50
Network	❑ Liberty ❑ Freedom	❑ Liberty ❑ Freedom	Liberty
Copayment: **a. PCP** **b. Specialist**	 Deductible then $25 per visit Deductible then $50 per visit	 $40 per visit $70 per visit	 $25 per visit $50 per visit
In-Network Deductible (Single/Family)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
In-Network Maximum Out-of-Pocket (Single/Family)	$4,500/$9,000	$6,600/$13,200	$6,600/$13,200
In-Network Coinsurance	20%	30%	30%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250	30% after Deductible has been met	30% after Deductible has been met
Inpatient Facility Copayment	20% after Deductible has been met	30% after Deductible has been met	30% after Deductible has been met
Emergency Room	Deductible then $250	$500	$500
Prescription Drug Coverage	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***	Tier 1 – $15 copayment Tier 2 – $45 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100	Tier 1 – $15 copayment Tier 2 – $65 copayment Tier 3 – $85 copayment Mail-Order – 2.5x copay Deductible** – $100

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

Silver Plans (Continued)

Option	❑ Oxford PPO HSA (Silver) $2000 30/60***	❑ Oxford PPO (Silver) 40/70
Network	Freedom	Freedom
Copayment: **a. PCP** **b. Specialist**	 Deductible then $30 per visit Deductible then $60 per visit	 $40 per visit $70 per visit
In-Network Deductible (Single/Family)	$2,000/$4,000	$2,000/$4,000
In-Network Maximum Out-of-Pocket (Single/Family)	$5,500/$11,000	$6,600/$13,200
In-Network Coinsurance	10%	30%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $150 Hospital Facility – Deductible then $250	30% after Deductible has been met
Inpatient Facility Copayment	10% after Deductible has been met	30% after Deductible has been met
Emergency Room	10% after Deductible has been met	$500
Out-of-Network Deductible (Single/Family)	$4,000/$8,000	$4,000/$8,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	$10,000/$20,000	$10,000/$20,000
Out-of-Network Coinsurance	50%	50%
Prescription Drug Coverage	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***	Tier 1 – $15 copayment Tier 2 – $45 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible** – $100

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year ❑ contract year basis.
*Referrals are required for this plan design.
**Deductible applies to Tier 2 and Tier 3 drugs.
***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. No individual on a multiple-person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket has been met.

Additional Benefit Options:
❑ Domestic Partner
❑ Mandated Offering – Dependent Age Extension to 29

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

III. PRODUCT AND PLAN DESIGNS (CONTINUED)

D. Bronze Plans

Option	❑ Oxford EPO HSA (Bronze) $5000***	❑ Oxford PPO HSA (Bronze) $5000 30/60*** MNRP	❑ Oxford PPO HSA (Bronze)$5000 30/60*** FAIR
Network	❑ Liberty ❑ Freedom	Liberty	Liberty
Copayment: **a. PCP** **b. Specialist**	 20% after Deductible has been met 20% after Deductible has been met	 Deductible then $30 per visit Deductible then $60 per visit	 Deductible then $30 per visit Deductible then $60 per visit
In-Network Deductible (Single/Family)	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
In-Network Maximum Out-of-Pocket (Single/Family)	$6,350/12,700	$6,450/$12,900	$6,450/$12,900
In-Network Coinsurance	20%	20%	20%
Outpatient Facility Copayment	20% after Deductible has been met	20% after Deductible has been met	20% after Deductible has been met
Inpatient Facility Copayment	20% after Deductible has been met	20% after Deductible has been met	20% after Deductible has been met
Emergency Room	20% after Deductible has been met	20% after Deductible has been met	20% after Deductible has been met
Out-of-Network Deductible (Single/Family)	N/A	$10,000/$20,000	$10,000/$20,000
Out-of-Network Maximum Out-of-Pocket (Single/Family)	N/A	$25,000/$50,000	$25,000/$50,000
Out-of-Network Coinsurance	N/A	20%	20%
Out-of-Network Reimbursement	N/A	140% MNRP^	80% FAIR^
Prescription Drug Coverage	Tier 1 – $10 copayment Tier 2 – $40 copayment Tier 3 – $80 copayment Mail-Order – 2.5x copay Deductible***	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***	Tier 1 – $15 copayment Tier 2 – $35 copayment Tier 3 – $75 copayment Mail-Order – 2.5x copay Deductible***

Deductibles and out-of-pocket accumulation periods are on a ❑ calendar year ❑ contract year basis.
**Deductible applies to Tier 2 and Tier 3 drugs.
***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. No individual on a multiple person contract may satisfy the individual deductible and maximum out-of-pocket until the entire family deductible or maximum out-of-pocket has been met.
^Deductible and out-of-pocket accumulation period for the plan are on a contract year basis

Additional Benefit Options:
❑ Domestic Partner
❑ Mandated Offering – Dependent Age Extension to 29

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

E. Metro Plans

Option	❑ Oxford Gated EPO (Platinum) $10/20[1]	❑ Oxford Gated EPO (Gold) $15/30[1]	❑ Oxford Gated EPO (Gold) $25/40[1]	❑ Oxford Gated EPO (Silver) $30/60[1]
Network	Metro	Metro	Metro	Metro
Copayment: **a. PCP** **b. Specialist**	 $10 per visit $20 per visit	 $15 per visit $30 per visit	 $25 per visit $40 per visit	 $30 per visit $60 per visit
In-Network Deductible (Single/Family)	N/A	$750/$1,500	$1,250/$2,500	$2,500/$5,000
In-Network Maximum Out-of-Pocket (Single/Family)	$3,000/$6,000	$3,500/$7,000	$4,500/$9,000	$5,600/$11,200
In-Network Coinsurance	N/A	20%	20%	30%
Outpatient Facility Copayment	Freestanding Facility – $100 Hospital Facility – $500	Freestanding Facility – Deductible then $200 Hospital Facility – Deductible then $500	Freestanding Facility – Deductible then $200 Hospital Facility – Deductible then $500	30% after Deductible has been met
Inpatient Facility Copayment	$200 per day to $800 maximum per admission	20% after Deductible has been met	20% after Deductible has been met	30% after Deductible has been met
Emergency Room	$200	$400	$400	30% after Deductible has been met
Prescription Drug Coverage	Tier 1 – $5 copayment Tier 2 – $65 copayment Tier 3 – 50% copayment to $800 maximum Mail-Order – 2.5x copay Deductible - N/A	Tier 1 – $5 copayment Tier 2 – $65 copayment Tier 3 – 50% copayment to $800 maximum Mail-Order – 2.5x copay Deductible - N/A	Tier 1 – $5 copayment Tier 2 – $65 copayment Tier 3 – 50% copayment to $800 maximum Mail-Order – 2.5x copay Deductible - N/A	Tier 1 – $10 copayment Tier 2 – $65 copayment Tier 3 – 50% copayment to $800 maximum Mail-Order – 2.5x copay Deductible - N/A

E. Metro Plans (Continued)

Option	❑ Oxford EPO HSA (Silver) $2000 35/50[1,3]	❑ Primary Advantage (Silver) $2000 30/60[1,2]	❑ Oxford EPO HSA (Bronze) $5000[1,3]	❑ Oxford EPO HSA (Bronze) $4250 40/75[1,3]
Network	Metro	Metro	Metro	Metro
Copayment: **a. PCP** **b. Specialist**	Deductible then $35 per visit Deductible then $50 per visit	$30 per visit Deductible then $60 per visit	30% after Deductible has been met 30% after Deductible has been met	Deductible then $40 per visit Deductible then $75 per visit
In-Network Deductible (Single/Family)	$2,000/$4,000	$2,000/$4,000	$5,000/$10,000	$4,250/$8,500
In-Network Maximum Out-of-Pocket (Single/Family)	$4,500/$9,000	$6,500/$13,000	$6,450/$12,900	$6,450/$12,900
In-Network Coinsurance	30%	30%	30%	40%
Outpatient Facility Copayment	Freestanding Facility – Deductible then $300 Hospital Facility – Deductible then $750	Freestanding Facility – Deductible then $300 Hospital Facility – Deductible then $750	30% after Deductible has been met	Freestanding Facility – Deductible then $400 Hospital Facility – Deductible then $1000
Inpatient Facility Copayment	30% after Deductible has been met	Deductible then $400 per day to $1,600 maximum per admission	30% after Deductible has been met	40% after Deductible has been met
Emergency Room	Deductible then $500	Deductible then $500	30% after Deductible has been met	Deductible then $500
Prescription Drug Coverage	Tier 1 – $10 copayment Tier 2 – $65 copayment Tier 3 – 50% copayment to $800 maximum Mail-Order – 2.5x copay Deductible[2]	Tier 1 – $10 copayment Tier 2 – $65 copayment Tier 3 – 50% copayment to $800 maximum Mail-Order – 2.5x copay Deductible[2]	Tier 1 – $10 copayment Tier 2 – $65 copayment Tier 3 – 50% copayment to $800 maximum Mail-Order – 2.5x copay Deductible[2]	Tier 1 – $10 copayment Tier 2 – $65 copayment Tier 3 – 50% copayment to $800 maximum Mail-Order – 2.5x copay Deductible[2]

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

[1] Referrals are required for this plan design.
Once the In-Network deductible has been satisfied by an individual, the applicable medical coinsurance will apply based on the selected plan. If the individual is enrolled as a couple, Parent/children or family and the family deductible is met, then no further deductible is required, and the applicable medical coinsurance will apply based on the selected plan.

[2] Referrals are required for this plan design. Deductible applies to Tier 2 and Tier 3 drugs.
NOTE: Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copayment will apply based on the selected plan. If the individual is enrolled as a couple, Parent/children or family and the family deductible is met, then no further deductible is required, and the applicable medical coinsurance and prescription drug copayment will apply based on the selected plan.

[3] Referrals are required for this plan design.
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. No individual enrolled as a couple, Parent/children or family may satisfy the deductible until the entire family deductible has been met. Each individual on a enrolled as a couple, Parent/children or family must satisfy the individual out-of-pocket maximum, until the entire family out-of-pocket maximum has been met.

Additional Benefit Options:

❑ Domestic Partner
❑ Mandated Offering – Dependent Age Extension to 29

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

IV. RATE INFORMATION

Monthly Rates: All new groups are subject to the four-tier rate structure indicated below. Rates must be included in the spaces below for application processing. Please note: All four categories must be completed.

Single	Couple	Parent/Children	Family
$	$	$	$

V. 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:			

VI. 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 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. 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.

VII. 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? _____

VIII. APPLICANT AGREEMENT

This Application and the premium rates proposed by Oxford are subject to 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. We reserve the right to modify rates in the event a plan design must be modified as a result of any change, modification or clarification in law. We also retain the right to correct typographical errors or discrepancies prior to the effective date of coverage, and take other actions (for example due to a misrepresentation of a material fact) as permitted by applicable state law.

I, the undersigned, on behalf of the above named company (the "Applicant") am applying for small group health coverage and understand that the information provided will be used to determine eligibility for coverage, premium rates and for other purposes. I confirm that all information gathered herein is accurately represented, complete, and that the Applicant is not aware of any information that was not disclosed.

The Applicant confirms that we employ no more than 100 full-time equivalent employees and at least 1 full-time equivalent employee.

The Applicant understands that this Application may be chosen for an audit to confirm the information provided. Audits may be conducted before or after enrollment. If documents reviewed or submitted during an audit show that the information provided on an application was false or that the group does not meet underwriting requirements, the group will not be enrolled (audit completed prior to enrollment) or will be terminated (audit completed post enrollment).

The Applicant understands that other audits may be conducted while the Group Policy and Group Enrollment Agreement is in effect and agrees that all documents or other information that may impact coverage or premiums will be available for inspection.

The Applicant hereby acknowledges and understands that this application does not constitute any obligation by Oxford to offer coverage and no insurance will be effective unless and until the application is formally accepted, in writing, by the Oxford entity underwriting the coverage. No contract of insurance is to be implied in any way on the basis of completion and/or submission of this Application.

If coverage is formally accepted, the Applicant understands that this application and any subsequent addenda (including, but not limited to, any member application forms and renewal certifications) will become part of the Group Policy and Group Enrollment Agreement issued by Oxford. Any material misrepresentation within the application or the addenda (whether intentional or unintentional) may subject the group to termination or other action permitted by law. By signing below, the Applicant agrees to be bound by the terms and conditions of the Group Policy and Group Enrollment Agreement. The plan documents (including, but not limited to, the application, policy certificate(s) and riders) will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan, and will govern in the event they conflict with any benefits comparison, summary of coverage or other description of the plan.

The Applicant agrees to offer coverage to all eligible employees and that only those employees or former employees and their spouses or dependants who are eligible for coverage will be enrolled.

By signing below, you are signing the group application on behalf of the group applying for coverage and stating that (1) I am the Applicant or the agent for the Applicant and am authorized to sign this Group Application and (2) the Applicant will be legally bound by the terms and conditions of the application, this authorization and the plan documents.

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 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 dollars and the stated value of the claim for each violation.

Dated at:_____this_____day of_____ 20_____.

_____

Full legal name of firm:_____

X_____

Signature of Authorized Company Representative | Title

_____

Witness | Duly Licensed Resident Agent/Broker

New York Member Enrollment Form – OHI

MAILING ADDRESS: P. O. Box 29142, Hot Springs, AR 71903 ▪ 1-800-444-6222 ▪ *www.oxfordhealth.com*

UnitedHealthcare®
Oxford

THANK YOU FOR CHOOSING AN OXFORD PRODUCT FOR YOU AND YOUR FAMILY.

IMPORTANT:

PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.

IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE, ALL FIELDS MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

- Use only blue or black ballpoint pen
- Enter all dates using the MM/DD/YYYY format
- Employer and employee signatures are required
- List any coordinating coverage (coverage in addition to this coverage)
- List any coverage you had prior to this coverage
- Attach disability paperwork, if applicable
- Check “full-time student” in the child column if the child is between the ages of 19-23 and a full-time student at an accredited institution
- Check “young adult” in the child column if the child is under the age of 30, eligible, and enrolling onto the young adult option. The young adult will also need to list their qualifying event, address and signature.
- Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL CUSTOMER SERVICE AT

1-800-444-6222

New York Member Enrollment Form – OHI

UnitedHealthcare® Oxford

MAILING ADDRESS: P. O. Box 29142, Hot Springs, AR 71903 ▪ 1-800-444-6222 ▪ *www.oxfordhealth.com*

A. Group Information (To be completed by the **employer**)				**Please print neatly using black or blue ballpoint pen ▪ ALL DATES MUST BE: MM/DD/YYYY**
Group Number Group Name	Plan CSP Billing Group	Date of Hire / /	Effective Date / /	Occupation
☐ On Leave of Absence ☐ Retired ☐ Union Employee ☐ Disabled	COBRA/Young Adult/SC Qualifying Event	Event Date / /	**Employer Signature** X	Date / /

B. Applicant Details (To be completed by the **employee**)	**Employee/Subscriber**	**Spouse**	**Child**	**Child**
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender and Disability Status: (Check appropriate boxes.)	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Full-time Student ☐ Young Adult	☐ Full-time Student ☐ Young Adult
Prior Carrier (List coverage prior to this.) ☐ Same for all	Carrier: Policy Number: From Date / / Through date: / /	/ / / /	/ / / /	/ / / /

C. Coordination of Benefits		**Employee/Subscriber**	**Spouse**	**Child**	**Child**
Medicare Coverage	Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all **Effective Date**: / /	Policy Number: Carrier: Policy Holder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policy Holder: Effective Date:	/ /	/ /	/ /	/ /

I understand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate. 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 five thousand dollars and the stated value of the claim for each such violation. I authorize any health provider or insurer to furnish Oxford any records concerning me or any enrolled member of my family for whom information is requested.

Employee's/Young Adult's Address	**(Apt #)**	**Employee's/Young Adult's Signature**	**Date**
		X	/ /
City	**State**	**ZIP Code**	

Group Name: _____
Policy #: _____

Oxford Health Plans
14 Central Park Drive
Hooksett, NH 03106
Attn: NY Small Group Enrollment Department

Dear Oxford,

Enclosed is the documentation you requested to verify my group's eligibility for group healthcare coverage in New York.

Below, I have indicated the number of eligible employees, my group's official filing status in New York State, and the documentation I have enclosed.

Number of eligible employees: _____

Official Group Filing in NY	Required Documentation*	Description
❑ New Corporation	Articles of Incorporation and W4 for each employee	Made up of shareholders who transfer money, property, or both for the corporation's capital stock.
❑ Existing Corporation	NYS-45 (indicating all eligible employees)	
❑ New Partnership	Partnership Agreement and W4 for each employee	A relationship that exists between two or more people who join to carry on a trade or business. Each person contributes money, property, labor, or skill, and each expects to share in the profits and losses of the business.
❑ Existing Partnership	K1 for each partner and NYS-45 (indicating all eligible non-partner employees)	
❑ NYSHIPP Approved Organization	NYSHIPP Certificate	The New York State Health Insurance Partnership Program (NYSHIPP) was established by the New York State Department of Health to assist eligible employees and sole proprietors without employees in purchasing small group health insurance policies for their full-time employees and dependents.
❑ New Proprietorship	W4 for each employee	An unincorporated business that is owned by one individual.
❑ Existing Proprietorship	Schedule C and NYS-45 (indicating all eligible employees)	
❑ New Subchapter S Corporation	CT6 and W4 for each employee	A domestic corporation that is formed to avoid double taxation. An S corporation is generally exempt from federal income tax. Its shareholders include on their tax returns their share of the corporation's separately stated items of income, deduction, loss, and credit, as well as their share of non-separately stated income or loss.
❑ Existing Subchapter S Corporation	1120S or K1 and NYS-45 (indicating all eligible employees)	
❑ New Limited Liability Corporation	Articles of Incorporation and W4 for each employee	May be classified as a partnership or corporation.
❑ Existing Limited Liability Corporation	NYS-45 (indicating all eligible employees)	

***Only fully executed documentation will be accepted.**

_____ _____ _____ _____

Signature of Authorized Employer Group Official Printed Name of Signee Date

New York Health Benefits Waiver of Coverage

UnitedHealthcare® Oxford

Mailing Address: Oxford Enrollment Dept. ■ P.O. Box 29142 ■ Hot Springs, AR 71903 ■ 1-800-444-6222 ■ www.oxfordhealth.com

Group Name: _____

Group Policy Number (if known): _____

Employee Name: _____

Marital Status**:** ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Date of Employment: _____

Date of Birth: _____

I am employed by and working at least 20 hours per week for the group shown above. I was given the opportunity to enroll in the Oxford* group health benefits plan(s) offered by my employer and I refuse coverage.

Reason for Refusal (please check all appropriate boxes)

❑ I have other coverage from:

- ❑ My spouse's employer
- ❑ Medicare
- ❑ Medicaid
- ❑ Veteran's Administration
- ❑ Union health plan
- ❑ Another carrier's group health plan sponsored by this employer
- ❑ Another source of coverage (please specify): _____

REQUIRED INFORMATION: _____

Name of Carrier Policy Number

❑ Other reason (please explain): _____

I certify that all information provided in this form is true and complete. By refusing group health benefits, I acknowledge that I and/or my dependent(s) may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Signature of Employee Date

Signature of Benefits Administrator Date

* Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

UnitedHealthcare Oxford

INSTRUCTION SHEET
Oxford* New York Small Group Tax Form Submissions

As part of the group enrollment process, we require that Oxford New York small groups submit tax documentation to verify that the group meets the eligibility requirements for healthcare coverage.

We require **the most recent copy** of your state **Quarterly Wage and Tax Report (NYS-45)**. If your company does not file a Quarterly Wage and Tax Report (NYS-45) or you have employees or owners who are not listed on the Quarterly Wage and Tax Report, please submit the following tax documentation, where applicable:

Official Group Filing in New York	Required Documents
Sole Proprietorship	**IRS Schedule C (Form 1040)** or **Schedule F** (farms)
S-Corporation	**Schedule K1 (Form 1120S)**
C-Corporation	**IRS Form 1120 (pages 1-2)**; include **Schedule K5** or **Form 1125-E or Schedule G** to identify owner(s)
Partnership / Limited Liability Company	**Schedule K1 (Form 1065)**
Limited Liability Company	Appropriately filed IRS schedule(s)
Non-Profit Company	Most recent quarter federal **Form 941** and current **two-week payroll report**
Group who filed a consolidated tax return as an affiliated group	Copy of most recent **IRS Form 851**
New Hires	Most recent **two-week payroll report**. Exception for new business: On an exception basis, we will allow a group to provide a W-4 if the new hire date is within two weeks of the effective date of coverage. Additional documentation for new hires may be subsequently requested.

Next to each employee listed on the tax documents, please indicate the following:

- State of residency
- Status code (from the list below)
- Date of hire or termination date (if applicable)

The submitted documents must identify all employees, owners, partners and contracted employees of your business – not only those who have Oxford medical coverage.

STATUS CODES			
A	Employee is actively enrolled (plan subscriber).	**S**	Employee is covered under spouse's employer plan.
M	Employee is covered under Medicare.	**O**	Employee has other coverage. Specify type of coverage (individual, another group plan, military [e.g., VA and Tricare], parental, Medicaid, etc.).
T	Employee is terminated (no longer works for this employer).	**D**	Employee is declining coverage (i.e., due to cost or doesn't want). Only use this code if the employee is full-time with no other coverage or waiver reason.
P	Employee is part-time and works less than the required full-time hours (includes temporary and seasonal employees).	**L**	Employee is not actively working due to Leave of Absence or other reason. Please provide the last tax form or payroll the employee is listed on.
W	Employee is full-time but is in the policy's waiting period. Indicate date of hire and date the employee will be eligible for coverage.	**C**	Person is covered under state or federal (COBRA) continuation law. Indicate continuation start date and whether coverage is provided by a prior employer or by your company.

*Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

