Program Design: Point-of-Service Plan
The Point-of-Service (POS) plans allow you to make a choice each time you need medical care. Choose a primary care physician who will coordinate all of your in-network medical care. In-network means you choose to see your primary care physician or an Oxford participating specialist with an authorized referral. Your out-of-pocket expenses will be lower when using in-network benefits.

If you visit a licensed physician who is not your primary care physician, or an Oxford participating specialist without an authorization, then you are using out-of-network benefits. In this case, your out-of-pocket expenses will be higher.

Metro Plan Features
The Freedom Plan Metro℠ (Options 4 and 5) program is designed to reduce health insurance premiums for you and your employees. By sharing some of the expense as you utilize healthcare services, if you use them at all, you get to realize up-front premium savings.

By utilizing in-network benefits, you have protection from significant medical expenses. There are no annual in-network deductibles or coinsurance requirements to satisfy. You’ll have higher copays on physician visits and hospital or surgi-center visits (both in and outpatient).

If you choose out-of-network providers, you must satisfy a $2,000 calendar-year deductible ($6,000 per family), and you are subject to varying coinsurance requirements. Payments to out-of-network providers are based on 140% of the standard Medicare rates which may be below what your provider charges. You are responsible for your coinsurance portion plus any additional amount charged by a non-network provider.

If You Use A Non-Network Provider!
If a Member receives treatment from a non-participating provider, the claim reimbursement check may be sent directly to the Member, rather than to the non-participating provider. The following process applies:
1. The non-participating provider will bill the covered Member for services rendered.
2. The reimbursement check the Member receives from Oxford will represent the benefit amount payable for the service. It will be attached to an Explanation of Benefits (EOB).
3. The Member is responsible for making payment to the non-participating provider for the full amount of the check, plus any applicable copayment, deductible, coinsurance or other cost share allowances, according to their benefit plan.

Alternative Medicine
The Choice Is Yours – Members can access a fully credentialed network of acupuncturists, chiropractors, massage therapists, yoga instructors and nutritionists at Oxford contracted rates or agreed upon fee discounts.

Healthcare Assistance – Oxford On-Call®, the 24-hour healthcare guidance service, is staffed by Registered Nurses.

Self-Service at www.oxhp.com – The interactive features of the Oxford web site empower Members to take a more active role in their healthcare and request educational materials.

Eligibility/Renewability
Society Members May Apply If: You are an employer group of one or more; you are actively engaged in the duties of your profession at least 20 hours per week; and you work in New York State. Sole proprietors may enroll during annual open enrollment periods each April.

Dependents Are Eligible To Apply, Provided They Are A Member’s: Lawful spouse or registered domestic partner; unmarried, dependent children under age 26.

Young Adult Option: Young adults through the age of 29 who do not have access to employer sponsored health insurance may continue their coverage through a parent’s health coverage once they reach the maximum age of dependency. This allows an eligible dependent to purchase his or her parent’s group coverage as an individual subscriber. To be eligible, the dependent child must be under age 30, not married, not insured or eligible for coverage as an employee or member under any employer sponsored plan and not be covered under Medicare.

Permanent, Full-Time Employees Are Eligible If: You are actively employed at least 20 hours per week; you work in New York State; and you work for a Society Member.

Member/Employee Coverage Will Terminate When: You are no longer working at least 20 hours per week; the period for which coverage has been paid ends; you are no longer a Society Member; you no longer work in New York; or you are no longer working full-time for a Society Member.

Dependent Coverage Will Terminate When: A person no longer qualifies as a dependent; the period for which coverage has been paid ends; or your coverage as a Society Member or employee ceases.
General Facts

Coordination Of Benefits – The benefits of this plan will be coordinated with the benefits of any other group health plan to which the individual is entitled.

Medicare is the primary coverage and Oxford Health Plans is secondary for employees with Medicare in firms with fewer than 20 employees.

Preexisting Conditions – A preexisting condition is a disease or a physical condition for which: a) a Member sought treatment, diagnosis or medical advice within six months immediately prior to becoming covered; or b) treatment, diagnosis or medical advice was actually recommended or received within six months immediately prior to becoming covered. However, credit will be given if you are covered by a qualified plan of coverage prior to enrolling in this program as required by law.

Medically Necessary – The benefits of this program shall be provided only to the extent that services are determined to be medically necessary. Oxford defines “medically necessary” as those services or supplies provided by a hospital, skilled nursing facility, physician or other provider, required to identify or treat your illness or injury that is determined by Oxford to be: a) consistent with the symptoms or diagnosis and treatment of your condition; b) appropriate with regard to standards of good medical practice; c) not solely for your convenience or that of any provider; and d) the most appropriate supply or level of service that can safely be provided. For inpatient services, it further means that your condition cannot safely be diagnosed or treated on an outpatient basis.

How To Apply

Please complete each question on the application and return it to Marsh. For more information, call 800-888-6926.
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FINANCIAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>None</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>$6,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>None</td>
<td>30%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket:</td>
<td>Not Applicable</td>
<td>$5,000</td>
</tr>
<tr>
<td>Single</td>
<td></td>
<td>(Including Deductible)</td>
</tr>
<tr>
<td>Family</td>
<td>Not Applicable</td>
<td>$15,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Including Deductible)</td>
</tr>
<tr>
<td>Maximum Lifetime Benefit</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Per Member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Network Reimbursement</td>
<td>N/A</td>
<td>149% of Medicare¹</td>
</tr>
<tr>
<td><strong>PREVENTIVE CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Preventive Care</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Pediatric Preventive Care</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td><strong>OUTPATIENT CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist office visits</td>
<td>$40 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Surgery **</td>
<td>$500 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Laboratory services</td>
<td>No Charge for UHC Lab</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Network providers</td>
<td></td>
</tr>
<tr>
<td>Magnetic Resonance Imaging</td>
<td>50% copayment to a max of</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>(MRI) **</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td><strong>ALLERGY CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial visit, and all</td>
<td>$40 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>subsequent visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HOSPITAL CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician's and surgeon's</td>
<td>No Charge</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-private room and</td>
<td>$500 copay per day</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>board **</td>
<td>($2,500 Calendar Year max)</td>
<td></td>
</tr>
<tr>
<td>All drugs and medication</td>
<td>No Charge</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td><strong>EMERGENCY CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>At hospital Emergency</td>
<td>$200 copay; (waived if</td>
<td>$200 copay; (waived if admitted)</td>
</tr>
<tr>
<td>Room</td>
<td>admitted)</td>
<td></td>
</tr>
<tr>
<td>(If member is admitted to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the Hospital, notification</td>
<td></td>
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</tr>
<tr>
<td>is required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care in Urgi-Center</td>
<td>$40 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td><strong>MATERNITY CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal and Post-natal</td>
<td>$25 copay per initial visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>care **</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital services for</td>
<td>$500 copay per day</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>mother and child **</td>
<td>($2,500 Calendar Year max)</td>
<td></td>
</tr>
<tr>
<td><strong>SHORT TERM REHABILITATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 consecutively</td>
<td>$500 copay per day</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>inpatient days per</td>
<td>($2,500 Calendar Year max)</td>
<td></td>
</tr>
<tr>
<td>condition per lifetime**</td>
<td>$40 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>60 Outpatient visits per</td>
<td></td>
<td></td>
</tr>
<tr>
<td>condition per lifetime</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HOME HEALTH CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 Home care visits**</td>
<td>$40 copay per visit</td>
<td>Subject to a 20% Coinsurance</td>
</tr>
<tr>
<td>Physician house calls</td>
<td>$40 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td><strong>SKILLED NURSING FACILITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>200 days per Calendar Year **</td>
<td>$500 copay per day</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td><strong>CHIROPRACTIC CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>$40 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td><strong>SUBSTANCE ABUSE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 days of Inpatient detox.</td>
<td>$500 copay per day</td>
<td>Subject to Deductible &amp; 50%</td>
</tr>
<tr>
<td>per Calendar Year**</td>
<td>($2,500 Calendar Year max)</td>
<td>Coinsurance</td>
</tr>
<tr>
<td>30 days of Inpatient rehab.</td>
<td>$500 copay per day</td>
<td>Subject to Deductible &amp; 50%</td>
</tr>
<tr>
<td>per Calendar Year**</td>
<td>($2,500 Calendar Year max)</td>
<td>Coinsurance</td>
</tr>
<tr>
<td>60 Outpatient rehab. visits</td>
<td>$40 copay per visit</td>
<td>Subject to Deductible &amp; 50%</td>
</tr>
<tr>
<td>per Calendar Year**</td>
<td></td>
<td>Coinsurance</td>
</tr>
<tr>
<td>BENEFIT</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>---------</td>
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<td>----------------</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 days of Inpatient care per Calendar Year**</td>
<td>$500 copay per day ($2,500 Calendar Year max)</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>30 Outpatient visits per Calendar Year***</td>
<td>$40 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>30 Office visits (combined w/outpatient visits)**</td>
<td>$40 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
</tbody>
</table>

**Biologically Based Mental Health Services & Services for Children with Serious Emotional Disorders**
(Visits for Biologically based services will count toward Non-Biologically based service limits.)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Care**</td>
<td>$500 copay per day ($2,500 Calendar Year max)</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Outpatient Care***</td>
<td>$40 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Office Visit***</td>
<td>$40 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
</tbody>
</table>

**PRESCRIPTION DRUGS**

| Includes Oral Contraceptives | $100 Deductible (Waived for Tier 1 Drugs) | Covered at Participating Pharmacies Only |
| Tier 1*** | $10 copayment | |
| Tier 2*** | $30 copayment | |
| Tier 3*** | $60 copayment | |

**HOSPICE CARE (210 days)**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient care</td>
<td>$500 copay per day ($2,500 Calendar Year max)</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>$500 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
</tr>
</tbody>
</table>

**EXERCISE FACILITY**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td>$200 reimbursement per 6 month period</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>$100 reimbursement per 6 month period</td>
<td></td>
</tr>
</tbody>
</table>

**HEARING AIDS**

Coverage is limited to $1,500.
Limited to a single purchase (including repair/replacement) every 3 years.

| | No Charge | Subject to Deductible & Coinsurance |

**OTHER COVERAGE**

| Medical Supplies** | \*\*\*OUT-OF-NETWORK BENEFIT ONLY | Subject to Deductible & Coinsurance |
| Durable Medical Equipment** | No Charge | Subject to Deductible & Coinsurance |
| $1500 limit per Calendar Year Pre-certification for items $500 or more. | |

**DEPENDENT ELIGIBILITY:**
Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Benefits discontinue at the end of the Calendar Year.

Domestic Partners are covered with proper documentation.

****The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles and/or maximum limits.

****Prescription medications ordered through the Mail Order Drug Program are subject to 2.5 times the applicable retail pharmacy copays for a 90 day supply

** These services require Pre-certification through Oxford. You must call Oxford at 1-800-444-6222 at least 14 days in advance of request.

Mental health and substance abuse services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.
Refer to the Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxford, cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders, Worker's Compensation, military service-related conditions or unless otherwise stated, dental services and vision correction services and supplies.

1 When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider’s billed charge.

Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropriate.
# Benefit Summary

## Financial

<table>
<thead>
<tr>
<th>Benefit</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>Single: None</td>
<td>$2,000</td>
</tr>
<tr>
<td></td>
<td>Family: None</td>
<td>$6,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>None</td>
<td>30%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket:</td>
<td>Single: Not Applicable</td>
<td>$5,000 (Including Deductible)</td>
</tr>
<tr>
<td></td>
<td>Family: Not Applicable</td>
<td>$15,000 (Including Deductible)</td>
</tr>
<tr>
<td>Maximum Lifetime Benefit Per Member</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Out-of-Network Reimbursement</td>
<td>N/A</td>
<td>140% of Medicare¹</td>
</tr>
</tbody>
</table>

## Preventive Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Preventive Care</td>
<td>No Charge</td>
<td>IN-NETWORK BENEFIT ONLY</td>
<td></td>
</tr>
<tr>
<td>Pediatric Preventive Care</td>
<td>No Charge</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>No Charge</td>
<td>No Charge</td>
<td></td>
</tr>
</tbody>
</table>

## Outpatient Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician office visits</td>
<td>$15 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Specialist office visits</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Surgery **</td>
<td>$250 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Laboratory services</td>
<td>No Charge for UHC Lab Network providers</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI) **</td>
<td>50% copayment to a max of $100</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

## Allergy Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial visit, and all subsequent visits</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

## Hospital Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician's and surgeon's services</td>
<td>No Charge</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Semi-private room and board **</td>
<td>$250 copay per day ($1,250 Calendar Year max)</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>All drugs and medication</td>
<td>No Charge</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

## Emergency Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Service</td>
<td>No Charge</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>At hospital Emergency Room (If member is admitted to the Hospital, notification is required)</td>
<td>$200 copay; (waived if admitted)</td>
<td>$200 copay; (waived if admitted)</td>
<td></td>
</tr>
<tr>
<td>Emergency Care in Urgi-Center</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

## Maternity Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and Post-natal care **</td>
<td>$15 copay per initial visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Hospital services for mother and child **</td>
<td>$250 copay per day ($1,250 Calendar Year max)</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

## Short Term Rehabilitation

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 consec. Inpatient days per condition per lifetime**</td>
<td>$250 copay per day ($1,250 Calendar Year max)</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>60 Outpatient visits per condition per lifetime</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

## Home Health Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 Home care visits**</td>
<td>$25 copay per visit</td>
<td>Subject to a 20% Coinsurance.</td>
<td></td>
</tr>
<tr>
<td>Physician house calls</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

## Skilled Nursing Facility

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 days per Calendar Year**</td>
<td>$250 copay per day ($1,250 Calendar Year max)</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

## Chiropractic Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic care</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

## Substance Abuse

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 days of Inpatient detox. per Calendar Year**</td>
<td>$250 copay per day ($1,250 Calendar Year max)</td>
<td>Subject to Deductible &amp; 50% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>30 days of Inpatient rehab. per Calendar Year**</td>
<td>$250 copay per day ($1,250 Calendar Year max)</td>
<td>Subject to Deductible &amp; 50% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>60 Outpatient rehab. visits per Calendar Year**</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>MENTAL HEALTH CARE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 days of Inpatient care per Calendar Year**</td>
<td>$250 copay per day ($1,250 Calendar Year max)</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>30 Outpatient visits per Calendar Year**</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>30 Office visits (combined w/outpatient visits)**</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Biologically Based Mental Health Services &amp; Services for Children with Serious Emotional Disorders</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Visits for Biologically based services will count toward Non-Biologically based service limits.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Care**</td>
<td>$250 copay per day ($1,250 Calendar Year max)</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Outpatient Care**</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Office Visit**</td>
<td>$25 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUGS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Oral Contraceptives</td>
<td>$100 Deductible (Waived for Tier 1 Drugs)</td>
<td>Covered at Participating Pharmacies Only</td>
<td></td>
</tr>
<tr>
<td>Tier 1****</td>
<td>$10 copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2****</td>
<td>$30 copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3****</td>
<td>$60 copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HOSPICE CARE (210 days)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient care</td>
<td>$250 copay per day ($1,250 Calendar Year max)</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Outpatient care</td>
<td>$250 copay per visit</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>EXERCISE FACILITY</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Subscriber</td>
<td>$200 reimbursement per 6 month period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>$100 reimbursement per 6 month period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HEARING AIDS</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Coverage is limited to $1,500.</td>
<td>No Charge</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Limited to a single purchase (including repair/replacement) every 3 years.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>OTHER COVERAGE</strong></td>
<td>OUT-OF-NETWORK BENEFIT ONLY</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Medical Supplies**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment**</td>
<td>No Charge</td>
<td>Subject to Deductible &amp; Coinsurance</td>
<td></td>
</tr>
<tr>
<td>$1500 limit per Calendar Year</td>
<td></td>
<td></td>
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<tr>
<td>Precertification for items $500 or more.</td>
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</tbody>
</table>

**DEPENDENT ELIGIBILITY:**
Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Benefits discontinue at the end of the Calendar Year.

Domestic Partners are covered with proper documentation.

****The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles and/or maximum limits.

****Prescription medications ordered through the Mail Order Drug Program are subject to 2.5 times the applicable retail pharmacy copays for a 90 day supply

** These services require **Precertification** through Oxford. You must call Oxford at 1-800-444-6222 at least 14 days in advance of request.

Mental health and substance abuse services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991. Refer to the Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxford, cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders, Worker's Compensation, military service-related conditions or unless otherwise stated, dental services and vision correction services and supplies.

1 When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.

Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropriate.
<table>
<thead>
<tr>
<th>I. GENERAL INFORMATION</th>
<th>Sole Proprietors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Full legal name of firm:</td>
<td></td>
</tr>
<tr>
<td>2. Address of firm:</td>
<td></td>
</tr>
<tr>
<td>(Street Address, City, State, Zip Code)</td>
<td></td>
</tr>
<tr>
<td>No P.O. Box</td>
<td></td>
</tr>
<tr>
<td>County:</td>
<td></td>
</tr>
<tr>
<td>3. Plan Administrator/Contact:</td>
<td></td>
</tr>
<tr>
<td>a. Name</td>
<td></td>
</tr>
<tr>
<td>b. Title</td>
<td></td>
</tr>
<tr>
<td>c. Address:</td>
<td></td>
</tr>
<tr>
<td>(If it differs from address of firm; cannot be a P.O. Box)</td>
<td></td>
</tr>
<tr>
<td>City, State, Zip</td>
<td></td>
</tr>
<tr>
<td>d. Phone Number</td>
<td></td>
</tr>
<tr>
<td>e. Fax Number</td>
<td></td>
</tr>
<tr>
<td>f. E-mail Address</td>
<td></td>
</tr>
<tr>
<td>4. Name and title of person to receive billing statements:</td>
<td></td>
</tr>
<tr>
<td>a. Name</td>
<td></td>
</tr>
<tr>
<td>b. Title</td>
<td></td>
</tr>
<tr>
<td>c. Address:</td>
<td></td>
</tr>
<tr>
<td>(If it differs from address of firm; cannot be a P.O. Box)</td>
<td></td>
</tr>
<tr>
<td>City, State, Zip</td>
<td></td>
</tr>
<tr>
<td>d. Phone Number</td>
<td></td>
</tr>
<tr>
<td>e. Fax Number</td>
<td></td>
</tr>
<tr>
<td>5. Full legal name of each subsidiary and/or affiliated company whose employees are to be covered (if applicable):</td>
<td></td>
</tr>
<tr>
<td>6. Nature of business:</td>
<td></td>
</tr>
<tr>
<td>7. SIC Code:</td>
<td></td>
</tr>
<tr>
<td>8. Tax identification number:</td>
<td></td>
</tr>
</tbody>
</table>
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: ________________________________ (Month / Day=1st / Year).

2. Anniversary date: April 1st

3. Open enrollment period: The open enrollment period will be the month prior to your anniversary date. The open enrollment effective date will be the first of the month following the period.

4. Total Number of Employees: ______________ / Number of Temporary/Contracted Workers: ______________

5. Employee Eligibility: All full-time, permanent employees who work at least 20 hours per week (minimum 20 hours/week) are eligible.

6. Number of Eligible Employees: Active Employees ______________

7. Number of Employees enrolling with Oxford Health Plans, with the new group application ______________

8. Number of Waivers for health coverage submitted ______________

9. Continuation of Coverage: Are you enrolling any former employees under COBRA or State Continuation Provisions? ☐ Yes ☐ No

   If yes, how many? ______________

Eligibility & Termination: the employee will become eligible on the latter of the effective date of this plan or the date selected below (check appropriate date).

CLASS I
Definition of Class I  All Full-Time ______________

   a) Waiting period ______________days from date of hire.

      Eligibility
      ☑ First of the month after the employee completes the waiting period.

      Termination
      On the last day of the calendar month in which employees' employment terminates.

   b) Should the waiting period be waived for rehire?
      ☑ Yes ☐ No
      (if rehired within ______________ months).

CLASS II
Definition of Class II ______________

   a) Waiting period ______________days/months from date of hire.

      Eligibility
      ☐ First of the month after the employee completes the waiting period.

      Termination
      On the last day of the calendar month in which employees' employment terminates.

   b) Should the waiting period be waived for rehire?
      ☐ Yes ☐ No
      (if rehired within ______________ months).
### III. PLAN DESIGNS

<table>
<thead>
<tr>
<th>Freedom Network:</th>
<th>Metro Option 4</th>
<th>Metro Option 5</th>
<th>Option 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Copayment:</strong></td>
<td>$25 per visit for PCP</td>
<td>$15 per visit for PCP</td>
<td>$25 per visit for PCP</td>
</tr>
<tr>
<td></td>
<td>$40 per visit for specialist</td>
<td>$25 per visit for specialist</td>
<td>$40 per visit for specialist</td>
</tr>
<tr>
<td><em><em>2. In-Network deductible</em>:</em>*</td>
<td>None</td>
<td>None</td>
<td>$1,000 single; $2,500 family</td>
</tr>
<tr>
<td><em><em>3. Out-of-Network deductible</em>:</em>*</td>
<td>$2,000 single; $6,000 family</td>
<td>$2,000 single; $6,000 family</td>
<td>$2,000 single; $5,000 family</td>
</tr>
<tr>
<td><strong>4. Coinsurance:</strong></td>
<td>Plan 70% / Member 30%</td>
<td>Plan 70% / Member 30%</td>
<td>Plan 80% / Member 20% Plan 60% / Member 40%</td>
</tr>
<tr>
<td><strong>5. Annual Out-of-Pocket Maximum:</strong></td>
<td>$5,000 Single</td>
<td>$5,000 Single</td>
<td>$6,000 Single</td>
</tr>
<tr>
<td>(Out-of-Network, including deductible)</td>
<td>$15,000 Family</td>
<td>$15,000 Family</td>
<td></td>
</tr>
<tr>
<td><strong>6. Out-of-Network reimbursement:</strong></td>
<td>140% of Medicare</td>
<td>140% of Medicare</td>
<td>140% of Medicare</td>
</tr>
<tr>
<td><strong>7. Pharmacy benefit:</strong></td>
<td>$10 / $30 / $60</td>
<td>$10 / $30 / $60</td>
<td>$10 / $30 / $60</td>
</tr>
<tr>
<td>Tier 1/2/3 Deductible:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$100 per contract yr. 4/1 – 3/31</td>
<td>$100 per contract yr. 4/1 – 3/31</td>
<td>$100 per calendar yr.</td>
<td></td>
</tr>
<tr>
<td>$25 / $75 / $150</td>
<td>$25 / $75 / $150</td>
<td>$25 / $75 / $150</td>
<td></td>
</tr>
<tr>
<td>Mail Order (90 day supply):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8. Inpatient facility copay:</strong> (In-Network)</td>
<td>$500 copay per day (2,500 Calendar year max.)</td>
<td>$250 copay per day (1,250 Calendar year max.)</td>
<td>Deductible and 20% copayment</td>
</tr>
<tr>
<td><strong>9. Outpatient surgery copay:</strong> (In-Network)</td>
<td>$500 copay</td>
<td>$250 copay</td>
<td>Deductible and 20% copayment</td>
</tr>
<tr>
<td><strong>10. Emergency room copay:</strong> (In-Network)</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
</tbody>
</table>

* Deductibles are on a calendar year basis and restart each January 1, except pharmacy deductibles for Metro 4 and 5, and the Metro EPO plans which are 4/1 – 3/31 of each year.

**Please note:** Out-of-Network Reimbursement Amount. Payments to out-of-network providers are based on 140% of the standard Medicare rates which may be below what your provider charges. You are responsible for your coinsurance portion plus any additional amount charged by a non-network provider. If a Member receives services from a facility or physician who does not participate in the Oxford Health Plans or UnitedHealthcare network of providers, claim payment may be made directly to the covered member instead of to the non-participating provider.

<table>
<thead>
<tr>
<th>Freedom Network:</th>
<th>Metro EPO 20-40</th>
<th>Metro EPO 25-50</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Copayment:</strong></td>
<td>$20 per visit for PCP</td>
<td>$25 per visit for PCP</td>
</tr>
<tr>
<td></td>
<td>$40 per visit for specialist</td>
<td>$50 per visit for specialist</td>
</tr>
<tr>
<td><em><em>2. In-Network deductible</em>:</em>*</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><em><em>3. Out-of-Network deductible</em>:</em>*</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>4. Coinsurance:</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>5. Annual Out-of-Pocket Maximum:</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>6. Out-of-Network reimbursement:</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>7. Pharmacy benefit:</strong> Tier 1/2/3 Deductible:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10 / $30 / $60</td>
<td>$10 / $30 / $60</td>
<td>$10 / $30 / $60</td>
</tr>
<tr>
<td>$100 per contract yr. 4/1 – 3/31</td>
<td>$100 per contract yr. 4/1 – 3/31</td>
<td>$100 per calendar yr.</td>
</tr>
<tr>
<td>$25 / $75 / $150</td>
<td>$25 / $75 / $150</td>
<td>$25 / $75 / $150</td>
</tr>
<tr>
<td>Mail Order (90 day supply):</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8. Inpatient facility copay:</strong> (In-Network)</td>
<td>$200 per day (1,000 Calendar year max.)</td>
<td>$300 per day (1,500 Calendar year max.)</td>
</tr>
<tr>
<td><strong>9. Outpatient surgery copay:</strong> (In-Network)</td>
<td>$200 copay</td>
<td>$300 copay</td>
</tr>
<tr>
<td><strong>10. Emergency room copay:</strong> (In-Network)</td>
<td>$200</td>
<td>$200</td>
</tr>
</tbody>
</table>

EPO: No benefits are provided for out-of-network services.
Group location and number of Members in each location:

- Bronx
- Queens
- Rockland
- Staten Island
- Brooklyn
- Westchester
- Putnam
- Nassau
- Manhattan
- Suffolk
- Orange
- Queens
- Westchester
- Putnam
- Nassau
- Staten Island
- Brooklyn
- Manhattan
- Rockland
- Suffolk
- Orange
- Queens
- Westchester
- Putnam
- Nassau
- Staten Island
- Brooklyn
- Manhattan
- Rockland
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- Orange
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VII. CONSENT

AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford Health Plans 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):

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

________________________  Remain in place until __________________________.

(Date)

Further, I agree that my company will be bound by the actions performed by the herein-named Broker or General Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about any Oxford Member.

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. Further, I hereby certify on behalf of the Applicant that the Applicant has not had a group health policy terminated within the past 12 months due to failure to pay premiums.

Dated at: ______________________________ this __________________________ day of ______________________________ 20__________.

Full legal name of firm:

The above named company confirms that we employ no more than 50 full-time non-union employees and no fewer than 1 full-time non-union employees. I understand that 1099-compensated individuals are not eligible for group coverage with Oxford Health Insurance unless they are considered sole proprietors. 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.

Signature of Authorized Officer of the Company

Title

Witness

OHI MTR 3/02   #58713 4228 4/11 Rev 3
### A. Group Information (To be completed by the employer)

<table>
<thead>
<tr>
<th>Group Number</th>
<th>Group Name</th>
<th>Plan CSP</th>
<th>Billing Group</th>
<th>Date of Hire</th>
<th>Effective Date</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY 2193</td>
<td></td>
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</tbody>
</table>

- [ ] On Leave of Absence
- [ ] Retired
- [ ] Must work min. 20 hrs/week
- [ ] Disabled

- COBRA/Young Adult/SC Qualifying Event

- Event Date

<table>
<thead>
<tr>
<th>Employer Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
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</tr>
</tbody>
</table>

### B. Applicant Details (To be completed by the employee)

<table>
<thead>
<tr>
<th>Social Security Number:</th>
<th>Employee/Subscriber</th>
<th>Spouse</th>
<th>Child</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

| First Name, Middle Initial: | | | |
|-----------------------------| | | |

| Date of Birth: (MM/DD/YYYY) | | | |
|-----------------------------| | | |

| Gender and Disability Status: (Check appropriate boxes.) | | | |
|----------------------------------------------------------| | | |
| [ ] M [ ] F / [ ] Disabled | | | |

| Primary Care Physician (PCP) ID Number: | | | |
|-----------------------------------------| | | |

| PCP Name: (If an existing patient of PCP, check “Yes”) | | | |
|-------------------------------------------------------| | | |
| [ ] Yes | | | |

| Check all that apply: | | | |
|----------------------| | | |
| [ ] Domestic Partner | | | |

- [ ] Under age 26
- [ ] Young Adult
- [ ] Under age 26
- [ ] Young Adult

- Prior Carrier

- (List coverage prior to this.)

<table>
<thead>
<tr>
<th>Carrier:</th>
<th>Policy Number:</th>
<th>From Date</th>
<th>Thru date:</th>
</tr>
</thead>
<tbody>
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</table>

| □ Same for all | | | |
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### C. Coordination of Benefits

<table>
<thead>
<tr>
<th>Medicare Coverage</th>
<th>Employee/Subscriber</th>
<th>Spouse</th>
<th>Child</th>
<th>Child</th>
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<tbody>
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</table>

| Check appropriate box and list effective date: | | | |
|------------------------------------------------| | | |
| [ ] Part A | | | |
| [ ] Part B | | | |
| [ ] Part D | | | |

| Pharmacy | | | |
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<table>
<thead>
<tr>
<th>Policy Number:</th>
<th>Carrier:</th>
<th>Policy Holder:</th>
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| □ Same for all | | | |
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### C. Coordination of Benefits

| Medical | | | |
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<table>
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<tr>
<th>Policy Number:</th>
<th>Carrier:</th>
<th>Policy Holder:</th>
<th>Effective Date:</th>
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</table>

| □ Same for all | | | |
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### I. Understanding and Certification

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 of whom information is requested.

<table>
<thead>
<tr>
<th>Employee’s Address (Apt #)</th>
<th>Employee’s Signature</th>
<th>Date</th>
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</table>

City
State
Zip

58713 (1/12) • d/b/a in CA Seabury & Smith Insurance Program Management • 777 S. Figueroa St., Los Angeles, CA 90017 • 800-888-6926 • NYCMS.Insurance@marsh.com • www.MarshAffinity.com

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