



SOLE PROPRIETOR HEALTH INSURANCE PROGRAMS -2010

	<input type="checkbox"/> Oxford Plan # 1 Freedom H.S.A. www.oxhp.com	<input type="checkbox"/> Oxford Plan #2 Freedom POS www.oxhp.com	<input type="checkbox"/> Oxford Plan #3 Liberty HMO www.oxhp.com	<input type="checkbox"/> Oxford Plan #4 Liberty EPO www.oxhp.com	<input type="checkbox"/> Oxford Plan #5 Freedom POS www.oxhp.com	<input type="checkbox"/> Oxford Plan #6 Freedom HSAs www.oxhp.com	<input type="checkbox"/> Oxford Plan #7 Liberty Direct POS www.oxhp.com	<input type="checkbox"/> Oxford Plan #8 Freedom EPO www.oxhp.com
Monthly Rates	Individual: \$531.69	Individual: \$765.01	Individual: \$446.00	Individual: \$573.71	Individual: \$666.21	Individual: \$393.70	Individual: \$597.54	Individual: \$604.49
	Emp & Spouse: \$1,158.17	Emp & Spouse: \$1,671.03	Emp & Spouse: \$969.19	Emp & Spouse: \$1,250.14	Emp & Spouse: \$1,453.68	Emp & Spouse: \$854.13	Emp & Spouse: \$1,302.58	Emp & Spouse: \$1,317.88
	Emp/Child(ren): \$975.51	Emp/Child(ren): \$1,406.76	Emp/Child(ren): \$816.60	Emp/Child(ren): \$1,052.87	Emp/Child(ren): \$1,224.00	Emp/Child(ren): \$719.84	Emp/Child(ren): \$1,096.95	Emp/Child(ren): \$1,109.81
	Family: \$1,627.87	Family: \$2,350.53	Family: \$1,361.60	Family: \$1,757.49	Family: \$2,044.25	Family: \$1,199.47	Family: \$1,866.62	Family: \$1,852.94
Referral Requirement	Referrals Required	Referrals Required	Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required
Deductible	In-Net: \$1250/\$2500	In-Net: N/A	In-Net: N/A	In-Net: N/A	In-Net: N/A	In-Net: \$2,850/\$5,700	In-Net: \$500/\$1,000	In-Net: N/A
	Out-Net: N/A	Out-Net: \$1,000/\$3,000	Out-Net: N/A	Out-Net: N/A	Out-Net: \$3,000/\$9,000	Out-Net: N/A	Out-Net: \$1,000/\$2,000	Out-Net: N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Out-Net: \$1,000,000	Unlimited
Coinsurance	In-Net: 100%	In-Net: 100%	In-Net: 100%	In-Net: 100%	In-Net: 100%	In-Net: 100%	In-Net: 90% of \$10,000	In-Net: 100%
	Out-Net: N/A	Out-Net: 70% of \$10,000	Out-Net: N/A	Out-Net: N/A	Out-Net: 70% of \$10,000	Out-Net: N/A	Out-Net: 70% of \$10,000	Out-Net: N/A
Office Co-payments	In-Net: 100% After Deductible	In-Net: \$25/\$40	In-Net: \$30/\$50 Copay	In-Net: \$25/\$50	In-Net: \$30/\$50	In-Net: 100% After Deductible	In-Net: 90% After Deductible	In-Net: \$25/\$50
	Out-Net: N/A	Out-Net: 70% after Deductible	Out-Net: N/A	Out-Net: N/A	Out-Net: 70% after Deductible	Out-Net: N/A	Out-Net: 70% after Deductible	Out-Net: N/A
Hospitals	In-Net: 100% After Deductible	In-Net: \$250 per day (\$1,250 calendar yr max), \$250 Outpatient Surgery Copay	In-Net: \$500 per day, \$1,000 max per admission Inpatient/\$150 Copay Outpatient Surgery	In-Net: \$300 per day (5 day max) Inpatient/\$300 Copay Outpatient Surgery	In-Net: \$500 per admission Inpatient/\$500 Copay Outpatient Surgery	In-Net: 100% After Ded	In-Net: 90% After Deductible	In-Net: \$300 per day (5 day max) Inpatient/\$300 Copay Outpatient Surgery
	In-Net: 100% After Deductible	Out-Net: 70% after Deductible	Out-Net: N/A	N/A	Out-Net: 70% After Deductible	N/A	Out-Net: 70% After Deductible	Out-Net: N/A
Prescription Benefits	Generic: \$10	Generic: \$10	Generic: \$15	Generic: \$10	Generic: \$15	Generic: \$10	Generic: \$15	Generic: \$10
	Preferred: \$25	Preferred: \$25	Preferred: \$35	Preferred: \$25	Preferred: \$30	Preferred: \$25	Preferred: \$30	Preferred: \$25
	Non-Preferred: \$50	Non-Preferred: \$50	Non-Preferred: \$75	Non-Preferred: \$50	Non-Preferred: \$60	Non-Preferred: \$50	Non-Preferred: \$60	Non-Preferred: \$50
	Subject to Deductible	\$50 Annual Deductible- Waived for Generic.	\$100 Annual Deductible- Waived for Generic.	\$50 Annual Deductible- Waived for Generic.	\$100 Annual Deductible- Waived for Generic.	Subject to Deductible	\$100 Annual Deductible- Waived for Generic.	\$100 Annual Deductible- Waived for Generic.
Emergency Room	In-Net: 100% After Deductible	\$75 Copay Waived If Admitted	\$150 Copay	\$75 Copay Waived If Admitted	\$150 Copay Waived If Admitted	In-Net: 100% After Ded	90% After Deductible	\$75 Copay Waived If Admitted
Dependents	19/23 yrs	19/23 yrs	19/23 yrs	19/23 yrs	19/23 yrs	19/23 yrs	19/23 yrs	19/23 yrs
Mental Health Inpatient (Biologically based mental health services treated as any other illness)	In-Net: \$100 % After Deductible-30 days max per calendar yr	In-Net: \$250 copay per day- 30 days per yr. max (\$1,250 Calendar max)	In-Net: \$500 per day/\$1000 max per confinement 30 days max per calendar yr	In-Net: \$300 per day (5 day max) 30 Days per calendar yr max.	In-Net: \$500 per admission- 30 Days per calendar yr max.	In-Net: 100% After Deductible-30 days per yr. max	In-Net: 90% After Deductible-30 days per yr. max	In-Net: \$300 per day (5 day max) 30 Days per calendar yr max.
	Out-Net: N/A	Out-Net: 70% after Deductible (30 days max per calendar yr.)	Out-Net: N/A	Out-Net: N/A	Out-Net: 50% after Deductible (30 days max per calendar yr.)	Out-Net: N/A	Out-Net: 70% after Deductible (30 days max per calendar yr.)	Out-Net: N/A
Mental Health Outpatient (Biologically based mental health services treated as any other illness)	In-Net: \$100 % After Deductible-30 days max per calendar yr	In-Net: \$40 Copay per office visit (30 visits max per calendar yr.)	In-Net: \$50 Copay-30 visits max per calendar yr	In-Net: \$50 Copay per office visit (30 visits max per calendar yr.)	In-Net: \$50 Copay per office visit (30 visits max per calendar yr.)	In-Net: 100% After Deductible-30 visits per yr. max	In-Net: 90% After Deductible-60 days per yr. max	In-Net: \$50 Copay per office visit (30 visits max per calendar yr.)
	Out-Net: N/A	Out-Net: 70% after Deductible (30 days max per calendar yr.)	Out-Net: N/A	Out-Net: N/A	Out-Net: 50% after Deductible (30 days max per calendar yr.)	Out-Net: N/A	Out-Net: 70% after Deductible (60 days max per calendar yr.)	Out-Net: N/A
Chiropractic	In-Net: 100% After Deductible	In-Net: \$40 Copay	In-Net: \$50 Copay	In-Net: \$50 Copay	In-Net: \$50 Copay	In-Net: 100% After Ded	In-Net: N/A	In-Net: \$50 Copay
	Out-Net: N/A	Out-Net: 70% After Deductible	Out-Net: N/A	N/A	Out-Net: 70% After Deductible	Out-Net: N/A	Out-Net: N/A	Out-Net: N/A

Payments are due monthly in advance to TriState Special Marketing Corp.

I have placed an "X" in the red box above the plan I have chosen.
 My new premium is \$_____ (rate includes \$10.00 monthly administrative billing fee) and a check in this amount is enclosed.

Please accept this completed form as acknowledgment of my 2010 plan election:

Signature _____ Date _____ Print Name _____ Company Name _____