



OXFORD SOLE PROPRIETOR HEALTH INSURANCE PLANS - 2010

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Oxford Plan # 1 Freedom H.S.A. www.oxhp.com	Oxford Plan # 2 Freedom POS www.oxhp.com	Oxford Plan # 3 Liberty HMO www.oxhp.com	Oxford Plan # 4 Liberty EPO www.oxhp.com	Oxford Plan # 5 Freedom POS www.oxhp.com	Oxford Plan # 6 Freedom HSAs www.oxhp.com	Oxford Plan # 7 Liberty Direct POS www.oxhp.com	Oxford Plan # 8 Freedom EPO www.oxhp.com
Quarterly Rates	Individual: \$1,595.67	Individual: \$2,295.03	Individual: \$1,338.00	Individual: \$1,721.13	Individual: \$1,998.63	Individual: \$1,161.10	Individual: \$1,792.62	Individual: \$1,813.47
	Emp & Spouse: \$3,474.51	Emp & Spouse: \$5,013.09	Emp & Spouse: \$2,907.57	Emp & Spouse: \$3,750.42	Emp & Spouse: \$4,361.04	Emp & Spouse: \$2,562.30	Emp & Spouse: \$3,907.74	Emp & Spouse: \$3,953.64
	Emp/Child(ren): \$2,926.53	Emp/Child(ren): \$4,220.28	Emp/Child(ren): \$2,449.80	Emp/Child(ren): \$3,158.61	Emp/Child(ren): \$3,672.00	Emp/Child(ren): \$2,159.52	Emp/Child(ren): \$3,290.85	Emp/Child(ren): \$3,329.43
	Family: \$4,883.61	Family: \$7,081.59	Family: \$4,084.80	Family: \$5,272.47	Family: \$6,132.75	Family: \$3,598.41	Family: \$5,599.86	Family: \$5,558.82
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.
	Annual Maximum: Unlimited	Annual Maximum: Unlimited	Annual Maximum: Unlimited	Annual Maximum: Unlimited	Annual Maximum: \$3,000	Annual Maximum: Unlimited	Annual Maximum: \$3,000	Annual Maximum: Unlimited
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 quarterly 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 \$30.00 quarterly 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 _____