

# SOLE PROPRIETOR HEALTH INSURANCE PROGRAMS - 2010



	Oxford Plan # 1 Freedom H.S.A. www.oxfip.com	Oxford Plan # 2 Freedom POS www.oxfip.com	Oxford Plan # 3 Liberty HMO www.oxfip.com	Oxford Plan # 4 Liberty EPO www.oxfip.com	Oxford Plan # 5 Freedom POS www.oxfip.com	Oxford Plan # 6 Freedom HSAs www.oxfip.com	Oxford Plan # 7 Liberty Direct POS www.oxfip.com	Oxford Plan # 8 Freedom EPO www.oxfip.com
<b>Monthly Rates</b>	Individual: \$531.89 Emp & Spouse: \$1,158.17 Emp/Child(ren): \$975.51 Family: \$1,627.87	Individual: \$765.01 Emp & Spouse: \$1,671.03 Emp/Child(ren): \$1,406.76 Family: \$2,350.53	Individual: \$446.00 Emp & Spouse: \$909.19 Emp/Child(ren): \$816.60 Family: \$1,361.60	Individual: \$573.71 Emp & Spouse: \$1,250.14 Emp/Child(ren): \$1,052.87 Family: \$4,757.49	Individual: \$666.21 Emp & Spouse: \$1,453.68 Emp/Child(ren): \$1,224.00 Family: \$2,044.25	Individual: \$393.70 Emp & Spouse: \$854.13 Emp/Child(ren): \$710.84 Family: \$1,199.47	Individual: \$597.54 Emp & Spouse: \$1,302.58 Emp/Child(ren): \$1,096.95 Family: \$1,866.62	Individual: \$604.49 Emp & Spouse: \$1,317.88 Emp/Child(ren): \$1,109.81 Family: \$1,852.94
<b>Referral Requirement</b>	Referrals Required	Referrals Required	Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required	
<b>Deductible</b>	In-Net: \$1250/\$2500 Out-Net: N/A	In-Net: N/A Out-Net: \$1,000/\$3,000	In-Net: N/A Out-Net: N/A	In-Net: N/A Out-Net: N/A	In-Net: N/A Out-Net: \$3,000/\$9,000	In-Net: \$2,850/\$5,700 Out-Net: N/A	In-Net: \$500/\$1,000 Out-Net: \$1,000/\$2,000	In-Net: N/A Out-Net: N/A
<b>Lifetime Maximum</b>	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	
<b>Coinsurance</b>	In-Net: 100%	In-Net: 100%	In-Net: 100%(radiology - 20% coinsurance upto \$100 per procedure)	In-Net: 100%	In-Net: 100%	In-Net: 100%	In-Net: 90% of \$10,000	In-Net: 100%
<b>Office Co-payments</b>	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
<b>Hospitals</b>	Out-Net: 100% After Deductible	Out-Net: 70% after Deductible	Out-Net: N/A	Out-Net: N/A	Out-Net: 70% after Deductible	Out-Net: 100% After Deductible	In-Net: 90% After Deductible	Out-Net: N/A
<b>Prescription Benefits</b>	Generic: \$10 Preferred: \$25 Non-Preferred: \$50 Subject to Deductible	Generic: \$10 Preferred: \$25 Non-Preferred: \$50	Generic: \$15 Preferred: \$35 Non-Preferred: \$75	Generic: \$10 Preferred: \$25 Non-Preferred: \$50	Generic: \$15 Preferred: \$30 Non-Preferred: \$60	Generic: \$10 Preferred: \$25 Non-Preferred: \$50	Generic: \$15 Preferred: \$30 Non-Preferred: \$60	Generic: \$10 Preferred: \$25 Non-Preferred: \$50
<b>Emergency Room</b>	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
<b>Dependents</b>	In-Net: 100% After Deductible-30 days max per calendar yr	In-Net: 70% after Deductible (30 days max per calendar yr)	Out-Net: N/A	Out-Net: N/A	In-Net: 50% after Deductible (30 days max per calendar yr)	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.
<b>Mental Health Inpatient (Biologically based mental health services treated as any other illness)</b>	In-Net: \$100 % After Deductible-30 days max per calendar yr	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
<b>Mental Health Outpatient (Biologically based mental health services treated as any other illness)</b>	In-Net: \$100 % After Deductible-30 days max per calendar yr	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)	In-Net: 100% After Deductible-30 visits per yr. max	In-Net: 90% After Deductible-60 days per yr. max	In-Net: \$50 Copy per office visit (30 visits max per calendar yr.)
<b>Chiropractic</b>	In-Net: 100% After Deductible	In-Net: \$40 Copy	In-Net: \$50 Copy	In-Net: \$50 Copy	In-Net: \$50 Copy	In-Net: 100% After Deductible	In-Net: N/A	In-Net: \$50 Copy

**\*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 \_\_\_\_\_ Company Name \_\_\_\_\_