

# OXFORD SOLE PROPRIETOR HEALTH INSURANCE PLANS - 2010

**THE BUSINESS COUNCIL OF WESTCHESTER**

	Oxford Plan #1 Freedom H.S.A. <a href="http://www.oxfdp.com">www.oxfdp.com</a>	Oxford Plan #2 Freedom POS <a href="http://www.oxfdp.com">www.oxfdp.com</a>	Oxford Plan #3 Liberty HMO <a href="http://www.oxfdp.com">www.oxfdp.com</a>	Oxford Plan #4 Liberty EPO <a href="http://www.oxfdp.com">www.oxfdp.com</a>	Oxford Plan #5 Freedom POS <a href="http://www.oxfdp.com">www.oxfdp.com</a>	Oxford Plan #6 Freedom HSAs <a href="http://www.oxfdp.com">www.oxfdp.com</a>	Oxford Plan #7 Liberty Direct POS <a href="http://www.oxfdp.com">www.oxfdp.com</a>	Oxford Plan #8 Freedom EPO <a href="http://www.oxfdp.com">www.oxfdp.com</a>
<b>Quarterly Rates</b>	Individual: \$1,995.67 Emp & Spouse: \$3,474.51 Emp/Child(ren): \$2,926.53 Family: \$4,883.61	Individual: \$2,995.03 Emp & Spouse: \$5,013.09 Emp/Child(ren): \$4,220.28 Family: \$7,081.59	Individual: \$1,238.00 Emp & Spouse: \$2,907.57 Emp/Child(ren): \$2,449.88 Family: \$4,084.80	Individual: \$1,721.13 Emp & Spouse: \$3,250.42 Emp/Child(ren): \$3,158.61 Family: \$5,272.47	Individual: \$1,998.63 Emp & Spouse: \$4,161.04 Emp/Child(ren): \$3,972.00 Family: \$6,132.75	Individual: \$1,181.10 Emp & Spouse: \$2,562.30 Emp/Child(ren): \$2,159.52 Family: \$3,598.41	Individual: \$1,792.62 Emp & Spouse: \$3,007.74 Emp/Child(ren): \$2,290.85 Family: \$5,599.86	Individual: \$1,813.47 Emp & Spouse: \$3,953.64 Emp/Child(ren): \$3,329.43 Family: \$5,558.82
<b>Referral Requirement</b>	Referrals Required	Referrals Required	Referrals Required	No 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	Unlimited
<b>Coinsurance</b>	In-Net: 100% Out-Net: N/A	In-Net: 100% Out-Net: 70% of \$10,000	In-Net: 100% (radiology - 20% coinsurance upto \$100 per procedure) Out-Net: N/A	In-Net: 100% Out-Net: N/A	In-Net: 100% Out-Net: 70% of \$10,000	In-Net: 100% Out-Net: N/A	In-Net: 90% of \$10,000 Out-Net: 70% of \$10,000	In-Net: 100% Out-Net: N/A
<b>Office Co-payments</b>	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
<b>Hospitals</b>	In-Net: 100% After Deductible	In-Net: \$250 per day (\$1,250 calendar yr max), \$250 Outpatient Surgery Copy	In-Net: \$500 per day (\$1,000 max per admission Inpatient/\$150 Copy Outpatient Surgery	In-Net: \$300 per day (5 day max) Inpatient/\$300 Copy Outpatient Surgery	In-Net: \$500 per admission Inpatient/\$500 Copy Outpatient Surgery	In-Net: 90% After Deductible	In-Net: 90% After Deductible	In-Net: \$300 per day (5 day max) Inpatient/\$300 Copy Outpatient Surgery
<b>Prescription Benefits</b>	Generic: \$10 Preferred: \$25 Non-Preferred: \$50 Subject to Deductible Annual Maximum: Unlimited	Generic: \$10 Preferred: \$25 Non-Preferred: \$75 \$100 Annual Deductible- Waived for Generic. Annual Maximum: Unlimited	Generic: \$15 Preferred: \$35 Non-Preferred: \$75 \$100 Annual Deductible- Waived for Generic. Annual Maximum: Unlimited	Generic: \$10 Preferred: \$25 Non-Preferred: \$50 \$50 Annual Deductible- Waived for Generic. Annual Maximum: Unlimited	Generic: \$15 Preferred: \$30 Non-Preferred: \$60 \$100 Annual Deductible- Waived for Generic. Annual Maximum: \$3,000	Generic: \$10 Preferred: \$25 Non-Preferred: \$50 Subject to Deductible Annual Maximum: Unlimited	Generic: \$15 Preferred: \$30 Non-Preferred: \$60 \$100 Annual Deductible- Waived for Generic. Annual Maximum: \$3,000	Generic: \$10 Preferred: \$25 Non-Preferred: \$50 \$100 Annual Deductible- Waived for Generic. Annual Maximum: Unlimited
<b>Emergency Room</b>	In-Net: 100% After Deductible 19/23 yrs	\$75 Copy Waived If Admitted 19/23 yrs	\$150 Copy 19/23 yrs	\$75 Copy Waived If Admitted 19/23 yrs	\$150 Copy Waived If Admitted 19/23 yrs	90% After Deductible 19/23 yrs	\$75 Copy Waived If Admitted 19/23 yrs	
<b>Dependents</b>	In-Net: \$100 % After Deductible-30 days max per calendar yr Out-Net: N/A	In-Net: \$250 copy per day- 30 days confinement 30 days max per calendar yr Out-Net: N/A	In-Net: \$500 per day/\$1000 max per confinement 30 days max per calendar yr Out-Net: N/A	In-Net: \$300 per day (5 day max) 30 days max per calendar yr max Out-Net: N/A	In-Net: \$500 per admission- 30 days per calendar yr max Out-Net: 50% after Deductible (30 days max per calendar yr)	In-Net: 100% After Deductible-30 days per yr. max Out-Net: N/A	In-Net: 90% After Deductible-30 days per yr. max Out-Net: 70% after Deductible (30 days max per calendar yr.)	
<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: N/A	In-Net: \$40 Copy per office visit (30 visits max per calendar yr) Out-Net: 70% after Deductible (30 days max per calendar yr.)	In-Net: \$50 Copy-30 visits max per calendar yr Out-Net: N/A	In-Net: \$50 Copy per office visit (30 visits max per calendar yr) Out-Net: N/A	In-Net: \$50 Copy per office visit (30 visits max per calendar yr) Out-Net: 50% after Deductible (30 days max per calendar yr.)	In-Net: 100% After Deductible-60 days per yr. max Out-Net: N/A	In-Net: \$50 Copy per office visit (30 visits 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 Out-Net: N/A	In-Net: \$40 Copy Out-Net: 70% After Deductible	In-Net: \$50 Copy Out-Net: N/A	In-Net: \$50 Copy Out-Net: N/A	In-Net: \$50 Copy Out-Net: 50% After Deductible	In-Net: 100% After Deductible Out-Net: N/A	In-Net: \$50 Copy Out-Net: N/A	
<b>Chiropractic</b>	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	

**\*Payments are due quarterly in advance to InState 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 \_\_\_\_\_