SMALL GROUP HEALTH INSURANCE PROGRAMS-2009

	Oxford Plan # 1 Freedom POS www.oxhp.com	**Oxford Plan #2 Freedom POS** www.oxhp.com	**Oxford Plan #3 Freedom Direct POS** 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
Monthly Rates	Individual: **$608.05**	Individual: **$560.66**	Individual: **$556.23**	Individual: **$425.08**	Individual **$498.06**	Individual **$287.73**	Individual **$432.06**	Individual **$447.37**
	Emp & Spouse: **$1,331.72**	Emp & Spouse: **$1,227.46**	Emp & Spouse: **$1,217.70**	Emp & Spouse: **$929.18**	Emp & Spouse: **$1,089.73**	Emp & Spouse: **$627.00**	Emp & Spouse: **$944.53**	Emp & Spouse: **$978.22**
	Emp/Child(ren): **$1,120.65**	Emp/Child(ren): **$1,032.97**	Emp/Child(ren): **$1,024.77**	Emp/Child (ren): **$782.16**	Emp/Child (ren): **$917.17**	Emp/Child (ren): **$528.05**	Emp/Child (ren): **$795.06**	Emp/Child (ren): **$823.39**
	Family: **$1,874.45**	Family: **$1,727.55**	Family: **$1,713.82**	Family: **$1,307.26**	Family: **$1,533.49**	Family: **$881.47**	Family: **$1,328.89**	Family: **$1,376.35**
Referral Requirement	Referrals Required	Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required
Deductible	In-Net: N/A	In-Net: N/A	In-Net: $500/$1,000	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: $1,000/$3,000	Out-Net: $1,000/$3,000	Out-Net: $1,000/$2,000	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	Out-Net: $1,000,000	Unlimited	Unlimited	Unlimited	Out-Net: $1,000,000	Unlimited
Coinsurance	In-Net: 100%	In-Net: 100%	In-Net: 90% of $10,000	In-Net: 100%	In-Net: 100%	In-Net: 100%	In-Net: 90% of $10,000	In-Net: 100%
	Out-Net: 70% of $10,000	Out-Net: 70% of $10,000	Out-Net: 70% of $10,000	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: $15/$25 Copay	In-Net: $25/$40	In-Net: $15/$25 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: 70% after Deductible	Out-Net: 70% after Deductible	Out-Net: 70% after Deductible	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 Inpatient Copay / $100 Outpatient Surgery Copay	In-Net: $250 per day ($1,250 calendar yr max), $250 Outpatient Surgery Copay	In-Net: 90% after Deductible	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
	Out-Net: 70% After Deductible	Out-Net: 70% after Deductible	Out-Net: 70% After Deductible	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: $10	Generic: $10	Generic: $15	Generic: $10	Generic: $15	Generic: $10
	Preferred: $25	Preferred: $25	Preferred: $25	Preferred: $25	Preferred: $30	Preferred: $25	Preferred: $30	Preferred: $25
	Non-Preferred: $50	Non-Preferred: $50	Non-Preferred: $50	Non-Preferred: $50	Non-Preferred: $60	Non-Preferred: $50	Non-Preferred: $60	Non-Preferred: $50
	$50 Annual Deductible- Waived for Generic.	$50 Annual Deductible- Waived for Generic.	$50 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	$75 Copay Waived If Admitted	$75 Copay Waived If Admitted	$100 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 per admission (30 days max per calendar yr.)	In-Net: $250 copay per day- 30 days per yr. max ($1,250 Calendar 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.	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: 70% after Deductible (30 days max per calendar yr.)	Out-Net: 70% 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: 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: $25 Copay per office visit (30 visits max per calendar yr.)	In-Net: $40 Copay per office visit (30 visits max per calendar yr.)	In-Net: 90% After Deductible-30 visits per yr. max	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: 70% after Deductible (30 days max per calendar yr.)	Out-Net: 70% 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: 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: $25 Copay	In-Net: $40 Copay	N/A	In-Net: $50 Copay	In-Net: $50 Copay	In-Net: 100% After Ded	N/A	In-Net: $50 Copay
	Out-Net: 70% After Deductible	Out-Net: 70% After Deductible	N/A	N/A	Out-Net: 70% After Deductible	N/A	N/A	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 $___________ (including $5.00 administrative billing fee) and a check in this amount is enclosed.

Please accept this completed form as acknowledgment of my 2009 plan election:

Signature **Date**