

	Oxford Liberty Lbty HMO 30/50/\$500(HMO)		Oxford Metro Lbty Metro 25-50/\$2000Ded/Coins/NG (EPOc)		Oxford Direct Lib Dir 30/50/80%/2000(POSc)	
	In-Network		In-Network	Out-Network	In-Network	Out-Network
Drug Card						
Prescription Card	15/35/75/Yes/100	UCR=N/A	15/30/60/Yes/100 \$3000 max/year	UCR=N/A	15/30/60/Yes/100 \$3000 max/year	UCR=140mc%
Major Medical						
Deductible Ind/Fam	N/A		\$2,000/\$4,000		\$2,000/\$4,000	
Co-Insurance	N/A		90%		80%	
Out-of-Pocket	N/A		\$3,000/\$6,000 (incl ded)		\$4,000/\$8,000 (incl ded)	
Office Co-pay	\$30		\$25		\$30	
DXL/Lab Fees	Lab-no charge; DXL-20% Coins up to \$100/procedure		No charge		Lab-no charge; DXL-Ded & Coins	
Specialist Co-pay	\$50		\$50		\$50	
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Hospital Benefits						
Hospital In-Patient	\$500/day; \$1,000 max/conf		Ded & Coins		Ded & Coins	
Hospital Out-Patient	\$150 copay		Ded & Coins		Ded & Coins	
Emergency Room	\$150 copay (wavier if admit)		\$75 copay (wavier if admit)		\$100 copay (wavier if admit)	
Private Nursing	Not covered		Not covered		Not covered	
Surgical Benefits						
Surgical In-Patient	\$500/day; \$1,000 max/conf		Ded & Coins		Ded & Coins	
Surgical Out-Patient	\$150 copay		Ded & Coins		Ded & Coins	
Mental Health						
Mental Nervous In-Patient	\$500/day; \$1,000 max/conf 30 days/cal yr		Ded & Coins 30 days/cal yr		Ded & Coins 30 days/cal yr	
Substance Abuse In-Patient	\$500/day; \$1,000 max/conf Rehab-30 days/cal yr Detox-7 days/cal yr		Ded & Coins Rehab-30 days/cal yr Detox-7 days/cal yr		Ded & Coins Rehab-30 days/cal yr Detox-7 days/cal yr	
Mental Nervous Out-Patient	\$50 copay 30 visits/cal yr		\$50 copay 30 visits/cal yr		\$50 copay 30 visits/cal yr	
Substance Abuse Out-Patient	\$30 copay 60 visits/cal yr		No charge 60 visits/cal yr		\$50 copay 60 visits/cal yr	
Other						
Well Care(Up to 19)	No charge		No charge		No charge	
Routine Adult Care	No charge		No charge		No charge	
Chiropractic Care	\$50 copay		\$50 copay		\$50 copay	
Home Health Care	\$30 copay; 40 visits/cal yr		20% Coins; 40 visits/cal yr		Coins; 40 visits/cal yr	
Non-Authorization	Refer to carrier		Refer to carrier		Refer to carrier	
Single	1 x	\$421.99	1 x	\$375.95	1 x	\$436.22
EE with Spouse	1 x	\$928.38	1 x	\$827.09	1 x	\$959.68
EE with Child(ren)	1 x	\$780.68	1 x	\$695.51	1 x	\$807.00
Family	1 x	\$1,308.17	1 x	\$1,165.44	1 x	\$1,378.46
Medicare	0	\$0.00	0	\$0.00	0	\$0.00
Monthly Cost	4	\$3,439.22	4	\$3,063.99	4	\$3,581.36
Annual Cost		\$41,270.64		\$36,767.88		\$42,976.32



Underwritten By



EXECUTIVE DENTAL & VISION

Red, White & Blue Triple Option Plan

Rates Valid until December 31, 2010

Co-Administered By



New York 3-99 Lives (50+ Lives contact your PGP Rep for Potential Large Group Discount)

The Employer selects either Red, White or Blue Plan

Each Employee selects either the CapDent, Managed Care or PPO Option within that plan.

Employees can change their Option only on the policy anniversary.

Vision Benefits Administered By

General Vision Services

Benefits

Dental Network
Network Option
Plan Option

Deductible

Annual Maximum

	Red Plan 3+ Lives			White Plan 10+ Lives			Blue Plan 10+ Lives		
	CapDent In Network Option 1	Managed Care In Network Option 2	PPO In/Out Network Option 3	CapDent In Network Option 1	Managed Care In Network Option 2	PPO In/Out Network Option 3	CapDent In Network Option 1	Managed Care In Network Option 2	PPO In/Out Network Option 3
Deductible	None	None	***\$50/\$150	None	None	***\$50/\$150	None	None	***\$50/\$150
Annual Maximum	None	None	\$1,000	None	None	\$1,500	None	None	\$2,000

***Deductible waived for Preventive Care

***Deductible waived for Preventive Care

***Deductible waived for Preventive Care

Diagnostic & Preventive

	Patient Copay	Patient Copay	Reimbursement %	Patient Copay	Patient Copay	Reimbursement %	Patient Copay	Patient Copay	Reimbursement %
Initial Oral Exam	No Charge	No Charge	100%	No Charge	No Charge	100%	No Charge	No Charge	100%
Single X-Rays	No Charge	No Charge	100%	No Charge	No Charge	100%	No Charge	No Charge	100%
Bitewing Series	No Charge	No Charge	100%	No Charge	No Charge	100%	No Charge	No Charge	100%
Full Mouth X-Rays	No Charge	No Charge	100%	No Charge	No Charge	100%	No Charge	No Charge	100%
Adult Prophylaxis/Child	No Charge	No Charge	100%	No Charge	No Charge	100%	No Charge	No Charge	100%
Fluoride Treatment	No Charge	No Charge	100%	No Charge	No Charge	100%	No Charge	No Charge	100%
Emergency Treatment	No Charge	No Charge	100%	No Charge	No Charge	100%	No Charge	No Charge	100%

Restorative

1 Surface Amalgam	\$20.00	No Charge	80%	\$20.00	No Charge	80%	\$20.00	No Charge	80%
2 Surfaces Amalgam	\$35.00	No Charge	80%	\$35.00	No Charge	80%	\$35.00	No Charge	80%
3 Surfaces Amalgam	\$50.00	No Charge	80%	\$50.00	No Charge	80%	\$50.00	No Charge	80%
1 Surface Composite	\$25.00	No Charge	80%	\$25.00	No Charge	80%	\$25.00	No Charge	80%
2 Surfaces Composite	\$40.00	No Charge	80%	\$40.00	No Charge	80%	\$40.00	No Charge	80%
3 Surfaces Composite	\$55.00	No Charge	80%	\$55.00	No Charge	80%	\$55.00	No Charge	80%

Oral Surgery

Routine Extraction	\$45.00	No Charge	80%	\$45.00	No Charge	80%	\$45.00	No Charge	80%
Surgical Extraction	\$75.00	\$35.00	80%	\$75.00	No Charge	80%	\$75.00	No Charge	80%
Soft Tissue Impaction	\$95.00	\$50.00	80%	\$95.00	No Charge	80%	\$95.00	No Charge	80%
Partial Bony Impaction	\$125.00	\$75.00	80%	\$125.00	No Charge	80%	\$125.00	No Charge	80%
Full Bony Impaction	\$160.00	\$100.00	80%	\$160.00	\$100.00	80%	\$160.00	No Charge	80%
Alveolectomy, Per Quad	\$95.00	\$75.00	80%	\$95.00	No Charge	80%	\$95.00	No Charge	80%

Root Canal Therapy

Pulpotomy	\$35.00	\$15.00	80%	\$35.00	No Charge	80%	\$35.00	No Charge	80%
Pulp Capping	\$10.00	\$5.00	80%	\$10.00	No Charge	80%	\$10.00	No Charge	80%
Root Canal, Anterior	\$225.00	\$125.00	80%	\$225.00	\$125.00	80%	\$225.00	\$50.00	80%
Root Canal, Bicuspid	\$290.00	\$190.00	80%	\$290.00	\$175.00	80%	\$290.00	\$100.00	80%
Root Canal, Molar	\$395.00	\$285.00	80%	\$395.00	\$225.00	80%	\$395.00	\$150.00	80%
Apicoectomy	\$175.00	\$125.00	80%	\$175.00	\$125.00	80%	\$175.00	\$50.00	80%

Periodontics -Per Quad

Scaling	\$25.00	\$10.00	50%	\$25.00	No Charge	50%	\$25.00	No Charge	50%
Gingivectomy	\$125.00	\$50.00	50%	\$125.00	\$50.00	50%	\$125.00	No Charge	50%
Osseous Surgery	\$425.00	\$275.00	50%	\$425.00	\$250.00	50%	\$425.00	\$200.00	50%

*Prosthetics - Crowns

Porcelain Crown	\$385.00	\$295.00	50%	\$385.00	\$275.00	50%	\$385.00	\$190.00	50%
Porcelain w/Metal Crown	\$425.00	\$295.00	50%	\$425.00	\$275.00	50%	\$425.00	\$190.00	50%
Stainless Steel Crown	\$95.00	\$75.00	50%	\$95.00	\$75.00	50%	\$95.00	\$75.00	50%
Cast Post	\$95.00	\$75.00	50%	\$95.00	\$75.00	50%	\$95.00	\$75.00	50%
Recement, Per Crown	\$35.00	\$20.00	50%	\$35.00	No Charge	50%	\$35.00	No Charge	50%
Recement, Per Bridge	\$35.00	\$25.00	50%	\$35.00	No Charge	50%	\$35.00	No Charge	50%
Full Upper/Lower Denture	\$395.00	\$295.00	50%	\$395.00	\$275.00	50%	\$395.00	\$190.00	50%
Partial Upper/Lower Denture	\$395.00	\$295.00	50%	\$395.00	\$275.00	50%	\$395.00	\$190.00	50%
Denture Reline	\$95.00	Lab Fee	50%	\$95.00	Lab Fee	50%	\$95.00	Lab Fee	50%
Denture Repairs	\$35.00 - \$95.00	Lab Fee	50%	\$35.00 - \$95.00	Lab Fee	50%	\$35.00 - \$95.00	Lab Fee	50%

*Orthodontics

(Dependents up to age 19) Maximum Case - 24 months	75% UCR	\$1,950.00	**Not Covered (optional benefit) Add'l premium	75% UCR	\$1,900.00	**Not Covered (optional benefit) Add'l Premium	75% UCR	\$1,700.00	**Not Covered (optional benefit) Add'l Premium
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** Optional Orthodontia enrolling 20 or more employees only

** Add \$8 to the Family & Parent/Child Rate

** Optional Orthodontia enrolling 20 or more employees only

** Add \$8 to the Family & Parent/Child Rate

** Optional Orthodontia enrolling 20 or more employees only

** Add \$8 to the Family & Parent/Child Rate

Rates

	Red Plan 3+ Lives	White Plan 10+ Lives	Blue Plan 10+ Lives
Single	\$15.25	\$24.50	\$37.50
Employee/Spouse	\$24.00	\$49.25	\$75.25
Parent/ Child	\$24.00	\$49.25	\$75.25
Family	\$32.00	\$58.50	\$89.50
Rate Guarantee	Two Years	Two Years	One Year

*Waiting Periods: No waiting period for Prosthetics, Crowns and Orthodontics under the CapDent and Managed Care options. Under the PPO option there is a 12 month waiting period for Prosthetics, Crowns and Orthodontics if the group has no prior coverage for these services. The 12 month waiting period is waived for groups with prior coverage under the PPO Option.

Important Underwriting Requirements

- All groups require 50% participation.
- Groups under 10 lives are required to submit NYS-45 Quarterly Wage Statement.
- Under the CapDent & Managed Care Option you may change your dentist with 30 days prior written notice.
- Firms where husband and wife are employed, one must pay the two party rate and list the other as a dependent.
- If family average exceeds 5 lives, additional premium of \$10.00 for each family member in excess of 5.
- Dependent Children: Covered to age 19, 25 if a full-time student.

Rev 10/09

This policy provides dental insurance only. The expected benefit ratio for this policy is 85%. The ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy.

Footnote Report

Prepared By: GABRIEL GITMEID
Prepared For: MITCHELL HIRSCHORN
Report Id: 14302406

Prepared On: 6/14/2010
Effective Date: 7/1/2010

Oxford Liberty

Rx Tier Structure
Description

Effective 1/1/2007, Pharmacy copayments are based on the following tier structure Tier 1 lowest copay, Tier 2 middle copay and Tier 3 highest copay. Please contact the carrier for additional information.

Oxford Metro

Rx Tier Structure
Description

Effective 1/1/2007, Pharmacy copayments are based on the following tier structure Tier 1 lowest copay, Tier 2 middle copay and Tier 3 highest copay. Please contact the carrier for additional information.

Oxford Direct

Rx Tier Structure
Description

Effective 1/1/2007, Pharmacy copayments are based on the following tier structure Tier 1 lowest copay, Tier 2 middle copay and Tier 3 highest copay. Please contact the carrier for additional information.

Oxford Liberty

Rider Specification

When selecting the Mental Health 30/20 Bio Rider (MH IP 30V / OP 20V BIO), the Mental Health 30/20 Non-Bio Rider (MH IP 30V / OP 20V NON-BIO) rider must be selected as well



EMBLEM PPO/EPO BENEFIT PLANS
Downstate Rate and Plan Design Comparison for
Sole Proprietors - 3rd Quarter 2010

	EMBLEM PPO HSA-Compatible		EMBLEM EPO HSA-Compatible	EMBLEM NON HSA High Deductible EPO 10,000
	In-Network	Out-of-Network	In-Network	In-Network
Allowed charges	GHI fee schedule		GHI fee schedule	
Deductible individual/family	\$5,000/ \$10,000	\$10,000/ \$20,000	\$5,800/\$11,600	\$10,000/\$20,000
Coinsurance	100%	80%	100%	100%
Out-of-pocket maximum	\$5,000/ \$10,000	\$12,000/ \$24,000	\$5,800/\$11,600	\$10,000/\$20,000
Annual physical check-up (adult)	Covered in full	Deductible and coinsurance	Covered in full	Covered in full
Diagnostic/lab fees	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Inpatient hospital coverage and inpatient medical services*	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Drug card	Covered in full after deductible	In-network only	Covered in full after deductible	Covered in full after deductible
Lifetime maximum	Unlimited	Unlimited	Unlimited	
Downstate Rates for 3rd Quarter 2010				
Employee	\$380.82		\$284.78	\$201.11
Family	\$1,077.79		\$799.26	\$556.60

*Precertification required.

The benefits described here are only brief highlights of the coverage available. Other cost-controlling options are available. Some benefits may have calendar year limits and/or maximums. The terms, limitations, conditions, and exclusions of the insurance contract and certificate will govern.

Policy form #: PLH-SGC-1000, et al.

Note: All GHI prescriptions are Voluntary Home Delivery and are NO LONGER mandatory

A \$14 monthly billing fee has been added to your premium.

DATED: 5/12/2010