

Chamber Benefits Group Small Group/Sole Proprietor Health Insurance Programs - 2011 Monthly

	Oxford Plan #1		Oxford Plan #2		Oxford Plan #3		Oxford Plan #4		Oxford Plan #5		Oxford Plan #6		Oxford Plan #7		Oxford Plan #8		
	Freedom HSA www.oxhp.com		Freedom POS www.oxhp.com		Liberty HMO www.oxhp.com		Liberty EPO www.oxhp.com		Freedom POS www.oxhp.com		Freedom HSA www.oxhp.com		Liberty Direct POS www.oxhp.com		Freedom EPO www.oxhp.com		
	Small Group	Sole Prop	Small Group	Sole Prop	Small Group	Sole Prop	Small Group	Sole Prop	Small Group	Sole Prop	Small Group	Sole Prop	Small Group	Sole Prop	Small Group	Sole Prop	
Individual:	\$565.60	\$647.44	\$736.16	\$843.58	\$449.92	\$514.41	\$590.41	\$675.97	\$733.72	\$840.78	\$421.53	\$481.76	\$651.36	\$746.06	\$633.94	\$726.03	
Emp/Child(ren):	\$1,031.00	\$1,182.65	\$1,346.54	\$1,545.52	\$816.94	\$936.48	\$1,076.89	\$1,235.42	\$1,396.30	\$1,602.75	\$764.47	\$876.14	\$1,189.66	\$1,365.11	\$1,157.43	\$1,328.04	
Emp/Spouse	\$1,220.32	\$1,400.37	\$1,595.55	\$1,831.88	\$965.82	\$1,107.69	\$1,274.90	\$1,463.14	\$1,590.18	\$1,825.71	\$903.36	\$1,035.86	\$1,408.99	\$1,617.34	\$1,370.67	\$1,573.27	
Family:	\$1,713.55	\$1,967.58	\$2,242.28	\$2,575.62	\$1,354.86	\$1,555.09	\$1,790.48	\$2,056.05	\$2,294.46	\$2,635.63	\$1,266.93	\$1,453.97	\$2,017.28	\$2,316.87	\$1,925.42	\$2,211.23	
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/\$1,250		In-Net: N/A		
	Out-Net: N/A		Out-Net: \$2,000/\$6,000		Out-Net: N/A		Out-Net: N/A		Out-Net: \$3,000/\$9,000		Out-Net: N/A		Out-Net: \$1,000/\$2,500		Out-Net: N/A		
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		
Coinsurance	In-Net: 100% After Deductible		In-Net: 100%(radiology- 50% Copayment to max of \$100)		In-Net: 100%(Radiology - 20% Coinsurance up to \$100 per Procedure/\$500 Max Per Calendar Yr)		In-Net: 100%(radiology- 50% Copayment to max of \$100)		In-Net: 100%(radiology- 50% Copayment to max of \$100)		In-Net: 100% After Deductible		In-Net: 80% of \$10,000		In-Net: 100%(radiology- 50% Copayment to max of \$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: 60% of \$25,000		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: \$25/\$40		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: 60% after Deductible		Out-Net: N/A		
Hospitals	In-Net: 100% After Ded		In-Net: \$500 Per Day (\$2,500 calendar yr max), \$500 Outpatient Surgery Copay		In-Net: \$500 Per Day to \$1,000 Max Per Continuous Confinement/\$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: 80% After Deductible		In-Net: \$300 Per Day (5 day max) Inpatient/\$300 Copay Outpatient Surgery		
	N/A		Out-Net: 70% after Deductible		N/A		N/A		Out-Net: 70% After Deductible		N/A		Out-Net: 60% After Deductible		Out-Net: N/A		
Prescription Benefits	Generic: \$10		Generic: \$10		Generic: \$15		Generic: \$10		Generic: \$10		Generic: \$10		Generic: \$10		Generic: \$10		
	Preferred: \$30		Preferred: \$30		Preferred: \$35		Preferred: \$30		Preferred: \$30		Preferred: \$30		Preferred: \$30		Preferred: \$30		
	Non-Preferred: \$60		Non-Preferred: \$60		Non-Preferred: \$75		Non-Preferred: \$60		Non-Preferred: \$60		Non-Preferred: \$60		Non-Preferred: \$60		Non-Preferred: \$60		
	Subject to Deductible		\$100 Annual Deductible		\$100 Annual Deductible		\$100 Annual Deductible		\$100 Annual Deductible		Subject to Deductible		\$100 Annual Deductible		\$100 Annual Deductible		
Annual Maximum: Unlimited		Annual Maximum: Unlimited		Annual Maximum: Unlimited		Annual Maximum: Unlimited		Annual Maximum: Unlimited		Annual Maximum: Unlimited		Annual Maximum: Unlimited		Annual Maximum: Unlimited		Annual Maximum: Unlimited	
Emergency Room	In-Net: 100% After Ded		\$200 Copay Waived If Admitted		\$150 Copay		\$200 Copay Waived If Admitted		\$200 Copay Waived If Admitted		In-Net: 100% After Ded		\$200 Copay Waived If Admitted		\$200 Copay Waived If Admitted		
Dependents	To Age 26		To Age 26		To Age 26		To Age 26		To Age 26		To Age 26		To Age 26		To Age 26		
Mental Health Inpatient (Biologically based mental health services treated as any other illness)	In-Net: 100% After Deductible-30 Days Max Per Yr		In-Net: \$500 Copay Per Day- 30 Days Max Per Yr (\$2,500 Calendar Max)		In-Net: \$500 Per Day to \$1,000 Max Per Continuous Confinement - 30 Days Max Per Calendar Yr		In-Net: \$300 Per Day (5 day max) 30 Days Max Per Calendar Yr		In-Net: \$500 Per Admission- 30 Days Max Per Calendar Yr		In-Net: 100% After Deductible-30 Days Max Per Yr		In-Net: 80% After Deductible-30 Days Max Per Yr		In-Net: \$300 Copay Per Day (5 Days Max) 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		Out-Net: N/A		Out-Net: Subject to Deductible & Co-Ins (30 days max per calendar yr.)		Out-Net: N/A		Out-Net: 60% 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 visits per yr. max		In-Net: \$40 Copay per office visit (30 visits max per calendar yr.)		In-Net: \$50 Copay		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: \$40 Copay per office visit (30 visits max per calendar yr.)		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: Subject to Deductible & Co-Ins (30 days max per calendar yr.)		Out-Net: N/A		Out-Net: 60% after Deductible (30 days max per calendar yr.)		Out-Net: N/A		
Chiropractic	In-Net: 100% After Ded		In-Net: \$40 Copay		In-Net: \$50 Copay		In-Net: \$50 Copay		In-Net: \$50 Copay		In-Net: 100% After Ded		N/A		In-Net: \$50 Copay		
	N/A		Out-Net: 70% After Deductible		N/A		N/A		Out-Net: 70% After Deductible		N/A		N/A		N/A		

My new premium is \$_____ and a check in this amount is enclosed.

Please accept this completed form as acknowledgment of my 2011 plan election:

Signature _____

Date _____

Print Name _____

Company Name _____

*Rates include a \$20.00 monthly administrative billing fee