CBG
Chamber Benefits Group

CBG Small Group Health Insurance Programs - 2018 Monthly Rates

Current Plans	**Plan # 1** (OX_P1 FS) **Oxford Freedom** **Silver EPO-H.S.A** www.oxhp.com	**Plan # 2** (OX_P2 LG) **Oxford Liberty** **Gold EPO** www.oxhp.com	**Plan # 3** (OX_P3 LP) **Oxford Freedom** **Platinum EPO** www.oxhp.com	**Plan # 4** (OX_P4 MS) **Oxford Metro** **Silver EPO** www.oxhp.com	**Plan # 5** **Aetna Network** **PPO Plan ***** www.aetna.com	**Plan # 6** **Aetna Network** **PPO Plan ***** www.aetna.com
Single:	**$743.83**	**$796.96**	**$1,056.14**	**$651.13**	**$588.00**	**$723.60**
Parent/Child(ren):	**$1,267.01**	**$1,357.33**	**$1,797.94**	**$1,109.41**	**$1095.15 ****	**$1308.96 ****
Couple:	**$1,482.66**	**$1,588.91**	**$2,107.29**	**$1,297.25**	**$1,181.25**	**$1,501.20**
Family:	**$2,093.66**	**$2,245.08**	**$2,983.76**	**$1,829.46**	**$1,481.55**	**$1,933.20**
Referrals	No Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required
Deductible (Ind/Fam)	In Network: $2,000/$4,000 NO Out-of-Network	In Network: $2,000/$4,000 NO Out-of-Network	In Network: N/A NO Out-of-Network	In Network: $2,500/$5,000 NO Out-of-Network	In-Net: NO Deductible Out-Net: NO Deductible	In-Net: NO Deductible Out-Net: NO Deductible
Coinsurance	In Network: 70% After Deductible NO Out-of-Network	In Network: 70% After Deductible NO Out-of-Network	In Network: 100% NO Out-of-Network	In Network: 70% NO Out-of-Network	In-Net & Out-Net: None	In-Net & Out-Net: None
Out Of Pocket Max (Ind/Fam)	In Network: $6,550/$13,100 NO Out-of-Network	In Network: $6,850/$13,700 NO Out-of-Network	In Network: $2,500/$5,000 NO Out-of-Network	In Network: $7,150/$14,300 NO Out-of-Network	In-Net: None Out-Net: None	In-Net: None Out-Net: None
Office Visit Co-payments	Subject to Deductible & Co-insurance	PCP - $30/ Spec - $60	PCP - $20/ Spec - $40	PCP - $30/ Spec - $60	In-Net: PCP $5 / Spec $50	In-Net: PCP $5 / Spec $30
	NO Out-of-Network	NO Out-of-Network	NO Out-of-Network	NO Out-of-Network	Out-Net: PCP $5 / Spec $50 + any amount over Medicare rate	Out-Net: PCP $5 / Spec $30 + any amount over Medicare rate
Hospitals	In-Network: Subject to Deductible & Co-insurance	In-Network: 70% Coinsurance	In-Network: $400 Copay Per Admission	In-Network: 70% Coinsurance	In-Net: Inpatient or Outpatient- $500 Copay	In-Net: Inpatient or Outpatient- $250 Copay
	NO Out-of-Network	NO Out-of-Network	NO Out-of-Network	NO Out-of-Network	Out Net: Inpatient or Outpatient $500 Copay + any amount over Medicare rate	Out Net: Inpatient or Outpatient $250 Copay + any amount over Medicare rate
Prescription Benefits	Generic: $15	Generic: $15	Generic: $5	Generic: $10	Generic: $5 Copay	Generic: $5 Copay
	Preferred: $35	Preferred: $45	Preferred: $30	Preferred: $65	Brand: $30 Copay	Brand: $30 Copay
	Non-Preferred: $75	Non-Preferred: $75	Non-Preferred: $60	Non-Preferred: $90	$3000 Annual Limit	$5000 Annual Limit
	Subject to Plan Deductible	$100 Annual Deductible (T2 & T3)	$50 Annual Deductible (T2 & T3)	$100 Annual Deductible	NO Annual Deductible	NO Annual Deductible
Mental Health	As any other illness	As any other illness	As any other illness	As any other illness	Not Covered	Not Covered
Emergency Room	Subject to Deductible & Co-insurance In & Out of Network	$500 In & Out of Network	$200 In & Out of Network	Subject to Deductible & Co-insurance In & Out of Network	In-Net: $300 (waived if admitted) Out-Net: $300 Copay + any amount over Medicare rate	In-Net: $200 (waived if admitted) Out-Net: $200 Copay + any amount over Medicare rate
Dependents	To Age 26	To Age 26	To Age 26	To Age 26	To Age 26	To Age 26
Urgent Care	Subject to Deductible & Co-insurance NO Out-of-Network	$75 NO Out-of-Network	$50 NO Out-of-Network	$80 NO Out-of-Network	In-Net: $50 Copay Out-Net: $50 Copay + any amount over Medicare rate	In-Net: $50 Copay Out-Net: $50 Copay + any amount over Medicare rate
Lab and X-rays	Subject to Deductible & Co-insurance NO Out-of-Network	Lab: 100% X-ray/Imaging: 70% NO Out-of-Network	Lab: 100%, X-ray: $90 per svc Imaging: Hospital $100, Elsewhere 100% NO Out-of-Network	Lab: 100% X-ray/Imaging: 70% NO Out-of-Network	In-Net: $5 Copay per visit Out-Net: $5 Copay + any amount over Medicare rate	In-Net: $5 Copay per visit Out-Net: $5 Copay + any amount over Medicare rate
Free Standing Outpatient Facility	Subject to Deductible & Co-insurance NO Out-of-Network	In-Network: 70% Coinsurance NO Out-of-Network	$100	In-Network: 70% Coinsurance NO Out-of-Network	Subject to Deductible/ Co-Insurance	Subject to Deductible/ Co-Insurance
Hospital Based Outpatient Facility	Subject to Deductible & Co-insurance NO Out-of-Network	In-Network: 70% Coinsurance NO Out-of-Network	$300	In-Network: 70% Coinsurance NO Out-of-Network	Subject to Deductible/ Co-Insurance	Subject to Deductible/ Co-Insurance
Major Diagnostic at Freestanding Facility	Subject to Deductible & Co-insurance NO Out-of-Network	Lab: 100% X-ray/Imaging: 70% NO Out-of-Network	Lab: 100%, X-ray: $90 per svc Imaging: 100% NO Out-of-Network	Lab: 100% X-ray/Imaging: 70% NO Out-of-Network	Subject to Deductible/ Co-Insurance	Subject to Deductible/ Co-Insurance
Major Diagnostic at Hospital	Subject to Deductible & Co-insurance NO Out-of-Network	Lab: 100% X-ray/Imaging: 70% NO Out-of-Network	Lab: 100%, X-ray: $90 per svc Imaging: $100 per svc NO Out-of-Network	Lab: 100% X-ray/Imaging: 70% NO Out-of-Network	Subject to Deductible/ Co-Insurance	Subject to Deductible/ Co-Insurance

*Rates include a $25 for Emp, $45 for Emp+, monthly administrative/billing fee. These rates are valid through December 2018.

** Employee + 1 Child ** Employee + 1 Child

***** PLAN 5: Annually, medical claims are paid at 100% of the plan's allowed amount until $30,000 in claims are paid. Thereafter, claims are paid at 60% of the plan's allowed amount and you are responsible for the remaining costs.**

***** PLAN 6: "Annually, medical claims are paid at 100% of the plan's allowed amount until $100,000 in claims are paid. Thereafter, claims are paid at 60% of the plan's allowed amount and you are responsible for the remaining costs."**

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