



Bright Choices™

Benefits Marketplace at a Glance - 4Q 2009

REINVENTING YOUR BENEFITS

The Chautauqua County Chamber of Commerce's new benefits program gives you more choice with lower costs. We have partnered with Liazon to develop the Bright Choices™ program, which gives you:

- Expanded choices for Medical, Dental, and Vision coverage
- A new way to learn about and enroll in your benefits online with the Bright Choices portal
- Help to retain quality employees and save money by offering a comprehensive benefits program
- More support than ever to handle administration and billing, facilitate employee enrollment, and answer employee questions about health insurance and other benefits

Questions? Call the Liazon Consumer Advocacy Team at 1-866-LIAZON-1

These plans are only available to businesses who choose to participate in the Bright Choices program.

Application Deadline: Applications are due 15 days prior to the month beginning coverage.

Administrative Fees: No administrative fees for participants in the Bright Choices program.

Rates: Health insurance rates only apply to groups with 50 or fewer total eligible employees. All other insurance products and rates apply to all groups, regardless of size. Billing is done monthly.

Participation Requirements:

Groups of 5 net eligibles and below must have 100% participation on a Univera product.

Groups of 6 net eligibles and above must have 75% participation on a Univera product.

Valid waivers include (exclusively):

- Coverage through a spouse with a commercial carrier or TRICARE
- Coverage through a parent who has commercial coverage
- Retiree coverage of the employee through a commercial coverage

This comparison has been prepared as a guide to assist you in evaluating the program. This is not a complete comparison or contract and in no way details all the benefits, limitations, or exclusions. Rates and terms are subject to change.



MEDICAL INSURANCE

Note: Univera rates will renew on 12/1/2010

Provision	Active — Co-Pay 1	Active — Co-Pay 2	Active — Hybrid 1 (Co-Pay + Deductible)	Active — Hybrid 2 (Co-Pay + Deductible)	Active — Hybrid 3 (Co-Pay + Deductible)	Active — HSA 1 (Lower Deductible)	Active — HSA 2 (Moderate Deductible)	Active — HSA 3 (Higher Deductible)
Preventive Care (Physical, Well-Child Visit, Mammogram, Pap Smear, Colonoscopy)	Free	Free	Free	Free	Free	Free	Free	Free
Physician Visit	\$25 (\$0 for Kids)	\$30 (\$0 for Kids)	\$25 (\$0 for Kids)	\$30 (\$0 for Kids)	\$30 (\$0 for Kids)	Deductible then 20%	Deductible then 0%	Deductible then 0%
Specialist Visit	\$40	\$50	\$40	\$50	\$50	Deductible then 20%	Deductible then 0%	Deductible then 0%
Hospital Stay	\$500	\$500	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 0%	Deductible then 0%
Outpatient Surgery	\$250	\$250	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 0%	Deductible then 0%
Maternity	Covered in Full	Covered in Full	All Services Deductible then 20% Nursery Care \$0	All Services Deductible then 20% Nursery Care \$0	All Services Deductible then 20% Nursery Care \$0	All Services Deductible then 20%	All Services Deductible then 0%	All Services Deductible then 0%
Emergency Room	\$250	\$250	\$150	\$250	\$250	Deductible then 20%	Deductible then 0%	Deductible then 0%
Ambulance	\$250	\$250	\$150	\$250	\$250	Deductible then 20%	Deductible then 0%	Deductible then 0%
Prescriptions (Generic Advantage Program applies*)	\$5/\$25/\$50 \$0 Generics for Kids	\$5/\$25/\$50 \$0 Generics for Kids Brand Deductible: \$250 per person/ \$750 family maximum	\$5/\$35/\$70 \$0 Generics for Kids Brand Deductible: \$250 per person/ \$750 family maximum	\$5/\$35/\$70 \$0 Generics for Kids Brand Deductible: \$250 per person/ \$750 family maximum	\$5/\$35/\$70 \$0 Generics for Kids Brand Deductible: \$250 per person/ \$750 family maximum	Deductible then \$5/\$35/\$70 \$0 Generics for Kids	Deductible then \$5/\$35/\$70 \$0 Generics for Kids	Deductible then 0%
Dependent Rider	Up to age 26 on all plans regardless of student status; Domestic partner covered.							
Deductible	In-Network: None Out-of-Network: \$500 Single \$1,500 Family	In-Network: None Out-of-Network: \$500 Single \$1,500 Family	In-Network: \$500 Single \$1,500 Family Out-of-Network: \$500 Single \$1,500 Family (Combined In/Out)	In-Network: \$1,000 Single \$3,000 Family Out-of-Network: \$1,000 Single \$3,000 Family (Combined In/Out)	In-Network: \$2,000 Single \$6,000 Family Out-of-Network: \$2,000 Single \$6,000 Family (Combined In/Out)	In-Network: \$1,300 Single \$2,600 Family Out-of-Network: \$1,300 Single \$2,600 Family (Combined In/Out)	In-Network: \$2,600 Single \$5,200 Family Out-of-Network: \$2,600 Single \$5,200 Family (Combined In/Out)	In-Network: \$5,500 Single \$11,000 Family Out-of-Network: \$5,500 Single \$11,000 Family (Combined In/Out)
Coinsurance	In-Network: None Out-of-Network: 20%	In-Network: None Out-of-Network: 20%	In-Network: 20% Out-of-Network: 40%	In-Network: 20% Out-of-Network: 40%	In-Network: 20% Out-of-Network: 40%	In-Network: 20% Out-of-Network: 40%	In-Network: 0% Out-of-Network: 0%	In-Network: 0% Out-of-Network: 0%
Out-of-Pocket Maximum	In-Network: None Out-of-Network: \$1,500 Single \$4,500 Family (Applies only to deductible)	In-Network: None Out-of-Network: \$1,500 Single \$4,500 Family (Applies only to deductible)	In-Network: \$1,500 Single \$4,500 Family Out-of-Network: \$1,500 Single \$4,500 Family	In-Network: \$3,000 Single \$9,000 Family Out-of-Network: \$3,000 Single \$9,000 Family	In-Network: \$6,000 Single \$18,000 Family Out-of-Network: \$6,000 Single \$18,000 Family	In-Network: \$3,000 Single \$6,000 Family Out-of-Network: \$3,000 Single \$6,000 Family	In-Network: \$5,500 Single \$11,000 Family Out-of-Network: \$5,500 Single \$11,000 Family	In-Network: \$5,500 Single \$11,000 Family Out-of-Network: \$5,500 Single \$11,000 Family
Premium (Monthly; Excluding Cash Back)	2-Tier Small Group \$418.68 Single \$1,100.48 Family 2-Tier Sole Proprietor \$481.47 Single \$1,265.52 Family	2-Tier Small Group \$396.50 Single \$1,043.26 Family 2-Tier Sole Proprietor \$455.98 Single \$1,199.77 Family	2-Tier Small Group \$371.85 Single \$978.85 Family 2-Tier Sole Proprietor \$427.62 Single \$1,125.65 Family	2-Tier Small Group \$336.32 Single \$884.62 Family 2-Tier Sole Proprietor \$386.76 Single \$1,017.27 Family	2-Tier Small Group \$305.44 Single \$802.71 Family 2-Tier Sole Proprietor \$351.26 Single \$923.15 Family	2-Tier Small Group \$230.97 Single \$611.71 Family 2-Tier Sole Proprietor \$265.62 Single \$703.49 Family	2-Tier Small Group \$208.01 Single \$551.53 Family 2-Tier Sole Proprietor \$246.59 Single \$653.01 Family	2-Tier Small Group \$143.04 Single \$378.49 Family 2-Tier Sole Proprietor \$164.48 Single \$435.22 Family
Cash Back	Cash Back program applies for all plans (up to \$525/year for Single and \$1,050 for Family).							

* Under the Generic Advantage Program, if you purchase a brand name prescription drug that has a generic equivalent, then you must pay (\$5 dollar copay for generic drug) + (actual cost of brand name drug) – (actual cost of generic drug). This program does not apply to drugs that only have generic alternatives. Doctor's orders cannot override this policy.

 **KeyBank** HEALTH SAVINGS ACCOUNT (HSA)

Account Setup and Fees	All accounts must be setup directly at your local Key Bank branch office or online at the link below: https://www.key.com/html/H-12.hsa.html (click the APPLY NOW button) No account opening or monthly account maintenance fees (Contact the Chamber for the Discount Code)						
Maximum Pretax Contributions	<table border="0"> <tr> <td>2009:</td> <td>2010:</td> </tr> <tr> <td>Single: \$3,000</td> <td>Single: \$3,050</td> </tr> <tr> <td>Family: \$5,950</td> <td>Family: \$6,150</td> </tr> </table> <p>Catch-up: An additional \$1,000 per year (if you're age 55 or older)</p>	2009:	2010:	Single: \$3,000	Single: \$3,050	Family: \$5,950	Family: \$6,150
2009:	2010:						
Single: \$3,000	Single: \$3,050						
Family: \$5,950	Family: \$6,150						
Balances	Account earns interest tax-free and balances roll over for future years						

 **MetLife** DENTAL INSURANCE

Note: MetLife rates will renew on 3/1/2010

Provision	Value Plan	Basic Plan	Enhanced Plan
Preventive	In-Network: 100% Out-of-Network: 80%	In-Network: 100% Out-of-Network: 90%	In-Network: 100% Out-of-Network: 100%
Basic	In-Network: 80% Out-of-Network: 50%	In-Network: 80% Out-of-Network: 70%	In-Network: 90% Out-of-Network: 80%
Major	In-Network: 0% Out-of-Network: 0%	In-Network: 50% Out-of-Network: 25%	In-Network: 60% Out-of-Network: 50%
Orthodontia	In-Network: 0% Out-of-Network: 0%	In-Network: 0% Out-of-Network: 0%	In-Network: 50% Out-of-Network: 50% (Lifetime Max: \$2,000/person)
Deductible	In-Network: \$0 Out-of-Network: \$50/person (\$150 family maximum; Applies to Basic and Major treatments only.)		
Calendar Year Maximum	In-Network: \$750/person Out-of-Network: \$500/person	In-Network: \$1,000/person Out-of-Network: \$750/person	In-Network: \$1,500/person Out-of-Network: \$1,000/person
Rates (Monthly)	Employee: \$16.40 Employee + Spouse: \$34.70 Employee + Child(ren): \$38.86 Family: \$57.83	Employee: \$29.57 Employee + Spouse: \$53.67 Employee + Child(ren): \$63.43 Family: \$91.37	Employee: \$42.51 Employee + Spouse: \$85.90 Employee + Child(ren): \$103.37 Family: \$147.69

Please [click here](#) for your Value Plan Summary. Please [click here](#) for your Basic Plan Summary. Please [click here](#) for your Enhanced Plan Summary. Included in each is a list of limitations and exclusions that pertain to your Dental Insurance coverage. On 3/1/2010, out-of-network coverage on the basic plan will increase to 90% for preventive services and 70% for basic services.

 **VSP** VISION INSURANCE

Note: Vision rates will renew on 3/1/2010

	Plan A	Plan B	Plan C
Eye Examination	1 per Year	1 per Year	1 per Year
Lenses	1 Every 2 Years	1 per Year	1 per Year
Frames	1 Every 2 Years	1 Every 2 Years	1 per Year
Rates (Monthly)	Single: \$8.43 Family: \$18.32	Single: \$9.61 Family: \$20.33	Single: \$12.57 Family: \$26.98

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