2017 Benefit Offerings Available to Individuals and Sole Proprietors

Enhanced Solutions Brought to you by Bene-Care Agency, LLC Benefits Advocate

Human Capital Management Solutions that encompass all activities needed to maintain a productive organization with engaged personnel.

For questions regarding plan offerings, enrollment options and business solutions, please contact

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Bene-Care Agency, LLC
Benefits Advocate

2017 BCBS of WNY Benefit Comparison for Individuals

In Network:	BCBS of WNY Platinum POS 110EX	BCBS of WNY Silver POS 7100	BCBS of WNY Bronze Standard HSA
Annual Deductible	**$0**	**$2,000 Single/ $4,000 Family**	**$5,500 Single / $11,000 Family**
Coinsurance	**0%**	**0%**	**50%**
Annual Out of Pocket Max	**$4,000 Single / $8,000 Family**	**$6,500 Single/ $13,000 Family**	**$6,550 Single/ $13,100 Family**
PCP Office Visit	$20 Copay	Deductible then $25 Copay	Deductible then 50% Coinsurance
Specialist Visit	$30 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance
Sick Child Visit	$20 Copay	Deductible then $25 Copay	Deductible then 50% Coinsurance
Radiology	$30 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance
Laboratory	$0 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance
Hospital Inpatient	$500 Copay	Deductible then $750 Copay	Deductible then 50% Coinsurance
Outpatient Surgery	$150 Copay	Deductible then $150 Copay	Deductible then 50% Coinsurance
Outpatient OT/PT/ST	$20 Copay	Deductible then $25 Copay	Deductible then 50% Coinsurance
Emergency Room Care	$100 Copay	Deductible then $250 Copay	Deductible then 50% Coinsurance
Ambulance	$100 Copay	Deductible then $250 Copay	Deductible then 50% Coinsurance
Urgent Care	$40 Copay	Deductible then $75 Copay	Deductible then 50% Coinsurance
Outpatient Mental Health	$30 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance
Chiropractor	$20 Copay	Deductible then $25 Copay	Deductible then 50% Coinsurance
Diabetic Supplies	$20 Copay	Deductible then $25 Copay	Deductible then 50% Coinsurance
Prescription Coverage	**Copay per 30 Day Supply** Tier 1 $5 Tier 2 $30 Tier 3 50%	**After Deductible** Tier 1 $5 Tier 2 $30 Tier 3 50%	**After Deductible** Tier 1 $10 Tier 2 $35 Tier 3 $70
)ut-of-Network: Deductible	$1,500 Single / $3,000 Family	$2,000 Single/$4,000 Family	$5,500 Single/$11,000 Family
Coinsurance	40%	N/A	Deductible then 50%
Annual Out of Pocket Max	$4,000 Single / $8,000 Family	$10,000 Single/$20,000 Family	$10,000 Single/$20,000 Family
Extra Benefits	$250 Wellness Card	$250 Wellness Card	$250 Wellness Card
Rates	**Option 1**	**Option 2**	**Option 3**
Single	**$618.79**	**$415.04**	**$368.84**
Subscriber and Spouse	**$1,237.58**	**$830.08**	**$737.68**
Subscriber and Child(ren)	**$1,051.94**	**$705.57**	**$627.03**
Family	**$1,763.55**	**$1,182.87**	**$1,051.19**

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2017 BCBS of WNY Benefit Comparison for Individuals

In Network:	BCBS of WNY Platinum Standard	BCBS of WNY Gold Standard	BCBS of WNY Silver Standard	BCBS of WNY Bronze Standard
Annual Deductible	**$0**	**$600 Single / $1,200 Family**	**$2,000 Single / $4,000 Family**	**$4,000 Single / $8,000 Family**
Coinsurance	**0%**	**0%**	**0%**	**$0**
Annual Out of Pocket Max	**$2,000 Single / $4,000 Family**	**$4,000 Single/ $8,000 Family**	**$6,750 Single/$13,500 Family**	**$7,150 Single/ $14,300 Family**
PCP Office Visit	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance
Specialist Visit	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance
Sick Child Visit	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance
Radiology	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance
Laboratory	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance
Hospital Inpatient	$500 Copay	Deductible then $1000 Copay	Deductible then $1,500 Copay	Deductible then 50% Coinsurance
Outpatient Surgery	$100 Copay	Deductible then $100 Copay	Deductible then $100 Copay	Deductible then 50% Coinsurance
Outpatient OT/PT/ST	$25 Copay	Deductible then $30 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance
Emergency Room Care	$100 Copay	Deductible then $150 Copay	Deductible then $250 Copay	Deductible then 50% Coinsurance
Ambulance	$100 Copay	Deductible then $150 Copay	Deductible then $150 Copay	Deductible then 50% Coinsurance
Urgent Care	$55 Copay	Deductible then $60 Copay	Deductible then $70 Copay	Deductible then 50% Coinsurance
Outpatient Mental Health	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance
Chiropractor	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance
Diabetic Supplies	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance
Prescription Coverage	**Not Subject to Deductible** Tier 1 $10 Tier 2 $30 Tier 3 $60	**Not Subject to Deductible** Tier 1 $10 Tier 2 $35 Tier 3 $70	**Not Subject to Deductible** Tier 1 $10 Tier 2 $35 Tier 3 $70	**After Deductible** Tier 1 $10 Tier 2 $35 Tier 3 $70
Out-of-Network: Deductible	$5,000 Single / $10,000 Family	$5,000 Single / $10,000 Family	$5,000 Single / $10,000 Family	$5,000 Single / $10,000 Family
Coinsurance	50%	50%	50%	50%
Annual Out of Pocket Max	$10,000 Single / $20,000 Family	$10,000 Single / $20,000 Family	$10,000 Single / $20,000 Family	$10,000 Single / $20,000 Family
Extra Benefits	$250 Wellness Card	$250 Wellness Card	$250 Wellness Card	$250 Wellness Card
Rates	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Single	**$615.62**	**$518.67**	**$437.46**	**$348.03**
Subscriber and Spouse	**$1,231.24**	**$1,037.34**	**$874.92**	**$696.06**
Subscriber and Child(ren)	**$1,046.56**	**$881.74**	**$743.69**	**$591.65**
Family	**$1,754.51**	**$1,478.21**	**$1,246.76**	**$991.88**

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2017 BCBS of WNY Benefit Comparison for Individuals

In Network:	BCBS of WNY / Erie Niagara Counties Only Platinum Optimum / Preferred	BCBS of WNY / Erie Niagara Counties Only Platinum Flexible / Participating	BCBS of WNY / Erie Niagara Counties Only Gold Optimum / Preferred	BCBS of WNY / Erie Niagara Counties Only Gold Flexible / Participating
Annual Deductible	**$0**	**$4,000 Single / $8,000 Family**	**$500 Single / $1,000 Family**	**$4,000 Single / $8,000 Family**
Coinsurance	**NA**	**50%**	**NA**	**50%**
Annual Out of Pocket Max	**$6,850 Single / $13,700 Family**		**$6,850 Single / $13,700 Family**	
PCP Office Visit	$10 Copay	Deductible then 50%	Deductible then $20 Copay	Deductible then 50% Coinsurance
Specialist Visit	$20 Copay	Deductible then 50%	Deductible then $40 Copay	Deductible then 50% Coinsurance
Sick Child Visit	$10 Copay	Deductible then 50%	Deductible then $20 Copay	Deductible then 50% Coinsurance
Radiology	$20 Copay	Deductible then 50%	Deductible then $40 Copay	Deductible then 50% Coinsurance
Laboratory	$20 Copay	Deductible then 50%	Deductible then $40 Copay	Deductible then 50% Coinsurance
Hospital Inpatient	$500 Copay	Deductible then 50%	Deductible then $750 Copay	Deductible then 50% Coinsurance
Outpatient Surgery	$100 Copay	Deductible then 50%	Deductible then $150 Copay	Deductible then 50% Coinsurance
Outpatient OT/PT/ST	$10 Copay	Deductible then 50%	Deductible then $20 Copay	Deductible then 50% Coinsurance
Emergency Room Care	$100 Copay	$100 Copay	Deductible then $150 Copay	Deductible then $150 Copay
Ambulance	$100 Copay	$100 Copay	Deductible then $150 Copay	Deductible then $150 Copay
Urgent Care	$40 Copay	Deductible then $40	Deductible then $50 Copay	Deductible then $50 Copay
Outpatient Mental Health	$20 Copay	Deductible then 50%	Deductible then $40 Copay	Deductible then 50% Coinsurance
Chiropractor	$10 Copay	Deductible then 50%	Deductible then $20 Copay	Deductible then 50% Coinsurance
Diabetic Supplies	$10 Copay	Deductible then 50%	Deductible then $20 Copay	Deductible then 50% Coinsurance
Prescription Coverage	**Not subject to deductible** Tier 1 $2 Tier 2 $25 Tier 3 50%		**Not subject to deductible** Tier 1 $5 Tier 2 $40 Tier 3 50%	
ut-of-Network: Deductible	$4,000 Single / $8,000 Family		$4,000 Single / $8,000 Family	
Coinsurance	50%		50%	
Annual Out of Pocket Max	$10,000 Single / $20,000 Family		$10,000 Single / $20,000 Family	
Extra Benefits	$250 Wellness Card		$250 Wellness Card	
Rates	**Option 1**		**Option 2**	
Single	**$543.33**		**$465.17**	
Subscriber and Spouse	**$1,086.66**		**$930.34**	
Subscriber and Child(ren)	**$923.66**		**$790.79**	
Family	**$1,548.49**		**$1,325.73**	

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2017 BCBS of WNY Benefit Comparison for Individuals

	BCBS of WNY / Erie Niagara Counties Only		BCBS of WNY / Erie Niagara Counties Only	
In Network:	**Silver Optimum / Preferred**	**Silver Flexible / Participating**	**Bronze Optimum / Preferred**	**Bronze Flexible / Participating**
Annual Deductible	**$2,000 Single / $4,000 Family**	**$5,000 Single / $10,000 Family**	**$5,500 Single / $11,000 Family**	**$7,150 Single / $14,300 Family**
Coinsurance	**NA**	**50%**	**NA**	**50%**
Annual Out of Pocket Max	**$6,450 Single / $12,900 Family**		**$7,150 Single / $14,300 Family**	
PCP Office Visit	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Specialist Visit	Deductible then $60 Copay	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Sick Child Visit	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Radiology	Deductible then $60 Copay	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Laboratory	Deductible then $60 Copay	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Hospital Inpatient	Deductible then $1,000 Copay	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Outpatient Surgery	Deductible then $200 Copay	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Outpatient OT/PT/ST	Deductible then $30 Copay	Deductible then $30 Copay	Deductible then 50%	Deductible then 0% Coinsurance
Emergency Room Care	Deductible then $200 Copay	Deductible then $200 Copay	Deductible then 50%	Deductible then 50% Coinsurance
Ambulance	Deductible then $200 Copay	Deductible then $200 Copay	Deductible then 50%	Deductible then 50% Coinsurance
Urgent Care	Deductible then $75 Copay	Deductible then $75 Copay	Deductible then 50%	Deductible then 0% Coinsurance
Outpatient Mental Health	Deductible then $60 Copay	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Chiropractor	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Diabetic Supplies	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Prescription Coverage	**After Deductible** Tier 1 $5 Tier 2 $50 Tier 3 50%		**After Deductible** Tier 1 $10 Tier 2 50% Tier 3 50%	
ut-of-Network: Deductible	$5,000 Single / $10,000 Family		$7,150 Single / $14,300 Family	
Coinsurance	50%		50%	
Annual Out of Pocket Max	$10,000 Single / $20,000 Family		$10,000 Single / $20,000 Family	
Extra Benefits	$250 Wellness Card		$250 Wellness Card	
Rates	**Option 3**		**Option 4**	
Single	**$397.02**		**$339.57**	
Subscriber and Spouse	**$794.04**		**$679.14**	
Subscriber and Child(ren)	**$674.93**		**$577.27**	
Family	**$1,131.51**		**$967.78**	

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2017 Independent Health Benefit Comparison for Individuals

In Network:	Independent Health FlexFit Platinum	Independent Health iDirect Gold Copay
Annual Deductible	**$0**	**$750 Single / $1,500 Family**
Coinsurance	**0%**	**0%**
Annual Out of Pocket Max	**$5,000 Single / $10,000 Family**	**$7,150 Single / $14,300 Family**
PCP Office Visit	$10 Copay	$15 Copay
Specialist Visit	$30 Copay	$45 Copay
Sick Child Visit	$10 Copay	$15 Copay
Radiology / Advanced Radiology	$30 Copay / $75 Copay	Deductible then $45 / $100 Copay
Laboratory	$10 Copay	Deductible then $25 Copay
Hospital Inpatient	$500 Copay	Deductible then $1,000 Copay
Outpatient Surgery	$150 Copay	Deductible then $150 Copay
Outpatient OT/PT/ST	$30 Copay	Deductible then $45 Copay
Emergency Room Care	$150 Copay	$200 Copay
Ambulance	$150 Copay	Deductible then $150 Copay
Urgent Care	$75 Copay	$75 Copay
Maternity Care	Pre/Postnatal Care: Covered in Full Delivery: $500 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $1,000 Copay
Outpatient Mental Health	$0 Copay	$0 Copay
Vision	$40 Copay	$40 Copay
Chiropractor	$30 Copay	$45 Copay
Diabetic Supplies	$10 Copay	Deductible then $15 Copay
Prescription Coverage	**Copay per 30 Day Supply** Tier 1 $4 Tier 2 $30 Tier 3 50%	**Copay per 30 Day Supply** Tier 1 $4 Tier 2 $30 Tier 3 50%
Out-of-Network: **Deductible** **Coinsurance** **Annual Out of Pocket Max**	 $2,000 Single/ $4,000 Family 40% Unlimited	 $2,500 Single/ $5,000 Family 40% Unlimited
Extra Benefits	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit
Rates	**Option 1**	**Option 2**
Single	**$597.36**	**$531.90**
Subscriber and Spouse	**$1,194.72**	**$1,063.80**
Subscriber and Child(ren)	**$1,015.51**	**$904.23**
Family	**$1,702.48**	**$1,515.92**

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2017 Independent Health Benefit Comparison for Individuals

In Network:	Independent Health iDirect Silver Copay HSAQ	Independent Health Max Silver	Independent Health iDirect Bronze HSAQ
Annual Deductible	**$2,000 Single/ $4,000 Family**	**$2,450 Single/ $4,900 Family**	**$4,425 Single/ $8,850 Family**
Coinsurance	**0%**	**0%**	**50%**
Annual Out of Pocket Max	**$6,550 Single/ $13,100 Family**	**$7,150 Single/ $14,300 Family**	**$6,550 Single/ $13,100 Family**
PCP Office Visit	Deductible then $35 Copay	$35 Copay	Deductible then 50% Coinsurance
Specialist Visit	Deductible then $60 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance
Sick Child Visit	Deductible then $35 Copay	$35 Copay	Deductible then 50% Coinsurance
Radiology	Deductible then $60 / $150 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance
Laboratory	Deductible then $35 Copay	Deductible then $35 Copay	Deductible then 50% Coinsurance
Hospital Inpatient	Deductible then $1,000 Copay	Deductible then $1,000 Copay	Deductible then 50% Coinsurance
Outpatient Surgery	Deductible then $200 Copay	Deductible then $150 Copay	Deductible then 50% Coinsurance
Outpatient OT/PT/ST	Deductible then $35 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance
Emergency Room Care	Deductible then $250 Copay	Deductible then $200 Copay	Deductible then 50% Coinsurance
Ambulance	Deductible then $250 Copay	Deductible then $200 Copay	Deductible then 50% Coinsurance
Urgent Care	Deductible then $75 Copay	$50 Copay	Deductible then 50% Coinsurance
Maternity Care	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $1000 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $1000 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then 50% Coinsurance
Outpatient Mental Health	Deductible then $0	Deductible then $50 Copay	Deductible then 50% Coinsurance
Vision	$40 Copay	$40 Copay	$40 Copay
Chiropractor	Deductible then $60	Deductible then $50	Deductible then 50% Coinsurance
Diabetic Supplies	Deductible then $35	Deductible then $35	Deductible then 50% Coinsurance
Prescription Coverage	**After Deductible** Tier 1 $10 Tier 2 $50 Tier 3 50%	**After Deductible (except Tier 1)** Tier 1 $10 Tier 2 $50 Tier 3 50%	**After Deductible** Tier 1 50% Tier 2 50% Tier 3 50%
Out-of-Network: **Deductible** **Coinsurance** **Annual Out of Pocket Max**	 $3,000 Single/ $6,000 Family 40% Unlimited	 $3,000 Single/ $6,000 Family 40% Unlimited	 $5,000 Single/ $10,000 Family 50% Unlimited
Extra Benefits	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit
Rates	**Option 1**	**Option 2**	**Option 3**
Single	**$446.66**	**$464.26**	**$387.91**
Subscriber and Spouse	**$893.32**	**$928.52**	**$775.82**
Subscriber and Child(ren)	**$759.32**	**$789.24**	**$659.45**
Family	**$1,272.98**	**$1,323.14**	**$1,105.54**

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2017 Independent Health Benefit Comparison for Individuals

In Network:	Independent Health Standard Platinum	Independent Health Standard Gold	Independent Health Standard Silver	Independent Health Standard Bronze	Independent Health Standard Catastrophic (< age 30 ONLY)
Annual Deductible	**$0**	**$600 Single/ $1,200 Family**	**$2,000 Single/ $4,000 Family**	**$4,000 Single/ $8,000 Family**	**$7,150 Single/ $14,300 Family**
Coinsurance	**0%**	**0%**	**0%**	**50%**	**0%**
Annual Out of Pocket Max	**$2,000 Single/ $4,000 Family**	**$4,000 Single/ $8,000 Family**	**$6,750 Single/ $13,500 Family**	**$7,150 Single/ $14,300 Family**	**$7,150 Single/ $14,300 Family**
PCP Office Visit	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay 3 visits not subject so deductible
Specialist Visit	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Sick Child Visit	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Radiology	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Laboratory	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Hospital Inpatient	$500 Copay	Deductible then $1,000 Copay	Deductible then $1,500 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Outpatient Surgery	$100 Copay	Deductible then $100 Copay	Deductible then $100 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Outpatient OT/PT/ST	$35 Copay	Deductible then $30 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Emergency Room Care	$100 Copay	Deductible then $150 Copay	Deductible then $250 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Ambulance	$100 Copay	Deductible then $150 Copay	Deductible then $150 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Urgent Care	$55 Copay	Deductible then $60 Copay	Deductible then $70 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Maternity Care	Pre/Postnatal Care: Covered in Full Delivery: $500 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $1,000 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $1,500 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then 50% Coinsurance	Pre/Postnatal Care: Covered in Full Delivery: Deductible then 0% Coinsurance
Outpatient Mental Health	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Vision	Not Covered	Not Covered	Deductible then $50 Copay	Not Covered	Not Covered
Chiropractor	$35 Copay	Deductible then $40 Copay	Not Covered	Deductible then 50% Coinsurance	Deductible then $0 Copay
Diabetic Supplies	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then $0 Copay
Prescription Coverage	**Copay per 30 Day Supply** Tier 1 $10 Tier 2 $30 Tier 3 $60	**Copay per 30 Day Supply** Tier 1 $10 Tier 2 $35 Tier 3 $70	**Copay per 30 Day Supply** Tier 1 $10 Tier 2 $35 Tier 3 $70	**After Deductible** Tier 1 $10 Tier 2 $35 Tier 3 $70	**After Deductible** Tier 1 $0 Tier 2 $0 Tier 3 $0
Out-of-Network: **Deductible** **Coinsurance** **Annual Out of Pocket Max**	 $2,000 Single/ $4,000 Family 40% Unlimited	 $2,500 Single/ $5,000 Family 40% Unlimited	 $3,000 Single/ $6,000 Family 40% Unlimited	 $5,000 Single/ $10,000 Family 50% Unlimited	 N/A N/A N/A
Extra Benefits	Health Extra's or Nutrition	Health Extra's or Nutrition	Health Extra's or Nutrition	Health Extra's or Nutrition	Health Extra's or Nutrition
Rates	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Single	**$623.30**	**$551.97**	**$486.16**	**$399.25**	**$160.74**
Subscriber and Spouse	**$1,246.60**	**$1,103.94**	**$972.32**	**$798.50**	**$321.48**
Subscriber and Child(ren)	**$1,059.61**	**$938.35**	**$826.47**	**$678.73**	**$273.26**
Family	**$1,776.41**	**$1,573.11**	**$1,385.56**	**$1,137.86**	**$458.11**

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Bene-Care Agency, LLC
Benefits Advocate

2017 Independent Health Benefit Comparison for Individuals

In Network:	Independent Health Choice Plus Platinum	Independent Health Choice Plus Gold	Independent Health Choice Plus Silver Copay HSAQ
Annual Deductible	**A: $0 Single B: $1,000 Single / $2,000 Family**	**A: $750 Single / $1,500 Family B: $2,000 Single / $4,000 Family**	**A: $2,000 Single/ $4,000 Family B: $3,425 Single / $6,850 Family**
Coinsurance	**A: 0% / B:40%**	**A: 0% / B: 50%**	**A:0% / B:50%**
Annual Out of Pocket Max	**A: $5,000 Single / $10,000 Family B:$6,450 Single / $12,900 Family**	**A: $6,850 Single / $13,700 Family B:$7,150 Single / $14,300 Family**	**A & B: $6,550 Single / $13,100 Family**
PCP Office Visit	A:$10 Copay B: Deductible then 40%	A:$15 Copay B:Deductible then 50%	Deductible then: A:$35 B:50%
Specialist Visit	A:$30 Copay B: Deductible then 40%	A:$45 Copay B:Deductible then 50%	Deductible then: A:$60 B:50%
Sick Child Visit	A:$10 Copay B: Deductible then 40%	A:$15 Copay B:Deductible then 50%	$35 Copay
Radiology / Advanced Radiology	A:$30 Copay / $75 Copay B: Deductible then 40%	Deductible then: A:$45 / $100 Copay B:50%	Deductible then: A:$60 / $150 Copay B:50%
Laboratory	A:$0 Copay B: Deductible then 40%	Deductible then: A:$25 Copay B:50%	Deductible then: A:$35 B:50%
Hospital Inpatient	A:$500 Copay B: Deductible then 40%	Deductible then: A:$1,000 Copay B:50%	Deductible then: A:$1,000 B:50%
Outpatient Surgery	A:$30 Copay B: Deductible then 40%	Deductible then: A:$150 Copay B:50%	Deductible then: A:$200 B:50%
Outpatient OT/PT/ST	A:$150 Copay B: Deductible then 40%	Deductible then: A:$45 Copay B:50%	Deductible then: A:$60 B:50%
Emergency Room Care	$150 Copay	$200 Copay	Deductible then $250 Copay
Ambulance	$150 Copay	Deductible then $150 Copay	Deductible then $250 Copay
Urgent Care	A:$75 Copay B: Deductible then 40%	A:$75 Copay B:Deductible then 50%	Deductible then: A:$75 B:50%
Maternity Care	Pre/Postnatal Care: Covered in Full Delivery: A: $500 Copay B: Deductible then 40%	Pre/Postnatal Care: Covered in Full Delivery: A: Deductible then $1000 Deductible B: Deductible then 50%	Pre/Postnatal Care: Covered in Full Delivery: AL Deductible then $1000 Copay B: Deductible then 50%
Outpatient Mental Health	$0 Copay	A: $0 B: Deductible then 50%	A: Deductible then $0 B: Deductible then 50%
Vision	A: $40 Copay B: Not applicable	A: $40 Copay B: Deductible then 50%	A: $40 B: Deductible then 50%
Chiropractor	A: $30 Copay B: Deductible then 40%	A: $45 Copay B: Deductible then 50%	A: Deductible then $60 B: Deductible then 50%
Diabetic Supplies	A: $10 Copay B: Deductible then 40%	A: Deductible then $15 Copay B: Deductible then 50%	A: Deductible then $35 B: Deductible then 50%
Prescription Coverage	**Copay per 30 Day Supply** Tier 1 $4 Tier 2 $30 Tier 3 50%	**Copay per 30 Day Supply** Tier 1 $4 Tier 2 $30 Tier 3 50%	**After Deductible (except Tier 1)** Tier 1 $10 Tier 2 $50 Tier 3 50%
Out-of-Network: **Deductible** **Coinsurance** **Annual Out of Pocket Max**	 $2,000 Single/ $4,000 Family 40% Unlimited	 $2,500 Single/ $5,000 Family 50% Unlimited	 $5,000 Single/ $10,000 Family 50% Unlimited
Extra Benefits	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit
Rates	**Option 1**	**Option 2**	**Option 3**
Single	**$569.71**	**$499.39**	**$426.98**
Subscriber and Spouse	**$1,139.42**	**$998.78**	**$853.96**
Subscriber and Child(ren)	**$968.51**	**$848.96**	**$725.87**
Family	**$1,623.67**	**$1,423.26**	**$1,216.89**

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2017 1st Quarter Univera Benefit Comparisons for Individuals

In-Network:	Univera Platinum Standard	Univera Gold Standard	Univera Silver Standard	Univera Bronze Standard	Univera Bronze Standard HSA
Deductible	**$0**	**$600 Single/ $1,200 Family**	**$2,000 Single/ $4,000 Family**	**$4,000 Single/ $8,000 Family**	**$5,500 Single/ $11,000 Family**
Coinsurance	**0%**	**0%**	**0%**	**50%**	**50%**
Out-of-Pocket Maximum	**$2,000 Single/ $4,000 Family**	**$4,000 Single/ $8,000 Family**	**$6,750 Single/ $13,500 Family**	**$7,150 Single/ $14,300 Family**	**$6,550 Single/ $13,100 Family**
Preventive Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
PCP Visits	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Specialist Visits	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Sick Child Visits	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Radiology	$15/$35 Copay	Deductible then $25/$40 Copay	Deductible then $30/$50 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Laboratory	$15/$35 Copay	Deductible then $25/$40 Copay	Deductible then $30/$50 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Hospital Inpatient	$500 Copay	Deductible then $1,000 Copay	Deductible then $1,500 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Outpatient Surgery	$100 Copay	Deductible then $100 Copay	Deductible then $100 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Outpatient OT/PT/ST	$25 Copay	Deductible then $30 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Emergency Room	$100 Copay	Deductible then $150 Copay	Deductible then $250 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Ambulance	$100 Copay	Deductible then $150 Copay	Deductible then $150 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Urgent Care	$55 Copay	Deductible then $60 Copay	Deductible then $70 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Mental Health Outpatient	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Chiropractor	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Diabetic Supplies	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Prescription Drug	**Copay per 30 Day Supply** Tier 1 $10 Tier 2 $30 Tier 3 $60	**Copay per 30 Day Supply** Tier 1 $10 Tier 2 $35 Tier 3 $70	**Copay per 30 Day Supply** Tier 1 $10 Tier 2 $35 Tier 3 $70	**After Deductible** Tier 1 $10 Tier 2 $35 Tier 3 $70	**After Deductible** Tier 1 $10 Tier 2 $35 Tier 3 $70
Out-of-Network: **Deductible** **Coinsurance** **Annual Out of Pocket Max**	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Extra Benefits	ExerciseRewards	ExerciseRewards	ExerciseRewards	ExerciseRewards	ExerciseRewards
Rates	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Subscriber	**$773.06**	**$665.69**	**$555.37**	**$401.14**	**$378.46**
Subscriber & Spouse	**$1,546.12**	**$1,331.37**	**$1,110.74**	**$802.28**	**$756.91**
Subscriber & Child(ren)	**$1,314.20**	**$1,131.66**	**$944.13**	**$681.94**	**$643.37**
Family	**$2,203.23**	**$1,897.21**	**$1,582.80**	**$1,143.24**	**$1,078.60**

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2017 Univera Benefit Comparisons for Individuals

In-Network:	Univera Platinum Select	Univera Gold Select	Univera Silver Select	Univera Bronze Select
Deductible **Coinsurance** **Out-of-Pocket Maximum**	**$0** **0%** **$6,350 Single/ $12,700 Family**	**$750 Single/ $1,500 Family** **0%** **$6,350 Single / $12,700 Family**	**$2,250 Single/ $4,500 Family** **20%** **$6,350 Single/ $12,700 Family**	**$5,000 Single/ $10,000 Family** **50%** **$6,550 Single/ $13,100 Family**
Preventive Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full
PCP Visits	$15 Copay	Deductible then $25 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Specialist Visits	$25 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Sick Child Visits	$15 Copay	Deductible then $25 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Radiology	$25 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Laboratory	$25 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Hospital Inpatient	$750 Copay	Deductible then $750 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Outpatient Surgery	$150 Copay	Deductible then $250 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Outpatient OT/PT/ST	$25 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Emergency Room	$150 Copay	Deductible then $250 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Ambulance	$150 Copay	Deductible then $250 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Urgent Care	$25 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Mental Health Outpatient	$25 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Chiropractor	$25 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Diabetic Supplies	$15 Copay	Deductible then $25 Copay	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Prescription Drug	**Copay per 30 Day Supply** Tier 1 $10 Tier 2 $35 Tier 3 $70	**Copay per 30 Day Supply** Tier 1 $10 Tier 2 $35 Tier 3 $70	**After Deductible** Tier 1 $10 Tier 2 $45 Tier 3 $90	**After Deductible** Tier 1 $10 Tier 2 40% Tier 3 50%
Out-of-Network: **Deductible** **Coinsurance** **Annual Out of Pocket Max**	Not Covered	Not Covered	Not Covered	Not Covered
Extra Benefits	ExerciseRewards	ExerciseRewards	ExerciseRewards	Exercise Rewards
Rates	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Subscriber	**$746.15**	**$639.11**	**$490.50**	**$371.38**
Subscriber & Spouse	**$1,492.30**	**$1,278.22**	**$981.00**	**$742.75**
Subscriber & Child(ren)	**$1,268.45**	**$1,086.49**	**$833.85**	**$631.34**
Family	**$2,126.52**	**$1,821.46**	**$1,397.93**	**$1,058.42**

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2017 Dental Plan Offerings

univera HEALTHCARE	Univera Dental
In Network:	
Preventative	**100%**
Basic	**80%**
Major	**50%**
Orthodontia	N/A
Individual Annual Deductible	$50
Family Annual Deductible	$150
Calendar Year Max per Dependent	$1,000
Rates	
Single	**$31.38**
Subscriber and Spouse	**N/A**
Subscriber and Child(ren)	**N/A**
Family	**$79.35**

DELTA DENTAL	Delta Dental
In Network:	
Preventative	**100%**
Basic	**80%**
Major	**50%**
Orthodontia	50%
Individual Annual Deductible	$50
Family Annual Deductible	$150
Calendar Year Max per Dependent	$1,000
Rates	
Single	**$39.81**
Subscriber and Spouse	**N/A**
Subscriber and Child(ren)	**N/A**
Family	**$96.04**

*Deductible waived for preventative services.
All Rates assume there will be a six-month waiting period on major, restorative and prosthodontic services for groups with no prior coverage.
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Univera requires 2 or more employees elect coverage in order to enroll.

MetLife	Metlife		
In Network:	**Value**	**Basic**	**Enhanced**
Preventative	**100%**	**100%**	**100%**
Basic	**80%**	**80%**	**80%**
Major	**0%**	**50%**	**60%**
Orthodontia	0%	0%	50%
Individual Annual Deductible	$0	$0	$0
Family Annual Deductible	$0	$0	$0
Calendar Year Max per Dependent	$750	$1,000	$1,500
Rates			
Single	**$21.06**	**$40.08**	**$55.87**
Subscriber and Spouse	**$44.25**	**$76.72**	**$110.30**
Subscriber and Child(ren)	**$49.40**	**$85.99**	**$123.59**
Family	**$74.26**	**$123.84**	**$179.92**

*Deductible waived for preventative services.
All Rates assume there will be a six-month waiting period on major, restorative and prosthodontic services for groups with no prior coverage.
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2017 Vision Plan Offering

MetLife	METLIFE			
In Network:	**Option 1 - M100D**	**Option 2 - M130D**	**Option 3 - M130A**	**Option 4 - M150A**
Allowance				
Frames	up to $100	up to $130	up to $130	up to $150
Contact Lenses	up to $100	up to $130	up to $130	up to $150
Copay	$20	$25	$25	$10
Coverage				
Eye Exam	$20 Copay (1 per Year)	$10		$5
Lens	once every 12 months	once every 12 months	once every 12 months	once every 12 months
Frame	once every 24 months	once every 24 months	once every 12 months	once every 12 months
Collection	Fendi, bebe, Calvin Klein, Nike, etc.			
Out Of Network	Subject to reimbursement schedule			
Rates				
Subscriber	**$6.90**	**$7.83**	**$8.71**	**$10.23**
Subscriber & Spouse	**$13.82**	**$15.56**	**$17.46**	**$20.51**
Subscriber & Child(ren)	**$11.68**	**$13.26**	**$14.76**	**$17.33**
Family	**$19.28**	**$21.89**	**$24.36**	**$28.61**

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2017 LTD and STD

MetLife

METLIFE	Long Term Disability		
Age Band	Low	Mid	High
<34	0.23	0.25	0.29
35-39	0.29	0.32	0.37
40 -44	0.46	0.51	0.59
45 - 49	0.63	0.69	0.81
50 - 54	1.03	1.14	1.32
55 - 59	1.78	1.96	2.28
60 - 64	2.35	2.59	3.01
65+	2.07	2.27	2.64
Limitations			
Elimination Period	180		

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MetLife

Carrier Name	Monthly Premiums for STD
Age Band	Rate
<30	0.670
30 - 34	0.670
35 - 39	0.670
40 - 44	0.670
45 - 49	0.700
50 - 54	0.860
55 - 59	1.190
60 - 64	1.400
65+	1.470
Limitations	
Elimination Period	7 days
Max Benefit Period	25 Weeks

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2017 Life and AD&D Coverage | Telehealth Discount Program

MetLife

	MedLife		
Service:	**Employee**	**Spouse**	**Children**
Benefit Amount	Up to $300,000 of coverage $100,000 guarentee issue for new groups only	Up to $100,000 of coverage $20,000 guarentee issue for new groups only	$10,000
Increment	$25,000	$10,000	$10,000
Monthly Rates	Varies by age and amount of coverage. From $0.10 to $1.85 per $1,000	Varies by age and amount of coverage. From $0.10 to $1.85 per $1,000	$1.90

Rates shown above are month. Employee must complete a Statement of Health Form for amounts exceeding Guaranteed Issue. Employee must elect self -only coverage in order to enroll a dependent. Dependent coverage may not exceed 50% of employee coverage. Children to age 21 or 26 if fulltime student

PHE CARD

	PHE			
Benefits:	**Dental**	**Preferred**	**Premier**	**Ultimate**
Telehealth: Save time with 24/7 access to a doctor by phone or online video consult.		X	X	X
Medical Bill Saver: Expert negotiators help members save on uncovered medical and dental bills over $400.		X	X	X
Medical Health Advisor: Members get one-on-one support from professionals for medical or insurance related issues.		X	X	X
Nurseline: Registered nurses are on-call 24/7 to answer member questions.		X	X	X
Doctors Online: Fast and easy way to get health information from an online resource that members can trust.		X	X	X
Vision: 10% to 60% off of glasses, contacts, laser surgery, eye exams and more.			X	X
Dental: Members can save big on dental services at thousands of locations nationwide.	X		X	X
Pharmacy: Members can save an average of 42% on their prescriptions, drastically reducing their out-of-pocket costs.		X	X	X
Lab Testing: Save 10% to 80% on typical costs for lab work at over 1,500 major clincal labs nationwide.				X
MRI & CT Scans: Save big on usual charges for MRI, CT Scans and Ultrasounds at throusands of radiology centers nationwide.				X
Hearing Aids: Members receive free initial screening and can save up to 35% at retail locations nationwide.				X
Durable Medical Equipment: Save 20% to 50% on walking aids, Wheelchairs, Orthopedic products and much more.				X
Monthly Rates	Plus $4.95 one-time application fee			
Employer Paid	$11.95	$12.95	$14.95	$18.85
Employee Paid	$11.95	$13.95	$15.95	$19.95
Direct to Consumer	$11.95	$14.95	$16.95	$19.95

This is not Insurance This plan is not insurance coverage and does not meet the minimum creditable coverage requirements under the Affordable Care Act. This plan provides discounts at certain healthcare providers for medical services. This plan does not make payments directly to the providers of medical services. The plan member is obligated to pay for all healthcare services but will receive a discount from those healthcare providers who have contracted with the discount plan organization. This discount program contains a 30-day cancellation. Member shall receive a full refund of membership fees, excluding registration fee if cancelled within the first 30 days after the effective date. Available only to NY Residents. Participating providers: www.mymemberportal.com

In addition to employee benefits, Bene-Care offers...

Third Party Administration

By providing our clients with in-house administration of cafeteria plans and funding arrangements, we have proven strategies that give you the confidence that your benefits package is working favorably towards your bottom line. Rather than decreasing coverage, our focus is to help your business add value to your employee benefits package.

We offer administration for the following:

- Section 125/105
- Health Reimbursement Accounts (HRA)
- Health Savings Accounts (HSA)
- Flexible Spending Accounts (FSA)

We also offer COBRA administration and Non-Discrimination compliance testing.

Payroll Services

Payroll from Bene-Care delivers all the functionality you need, plus a portfolio of added advantages you'll_ appreciate. Save time and money, streamline administration, get information faster and more accurately all thanks to benefit synergy and payroll from Bene-Care.

- Payroll Processing
- Tax Payment & Regulatory Compliance Services
- Benefits Administration
- Applicant Tracking & Employee On-boarding Tools
- Time and Labor
- Human Resource Management

Please contact Bene-Care at 716.688.8161 with any questions you may have, or for more information on product and service offerings. We are available Monday through Friday from 8:30am – 5:00pm.

Thank you, and we look forward to working with you!