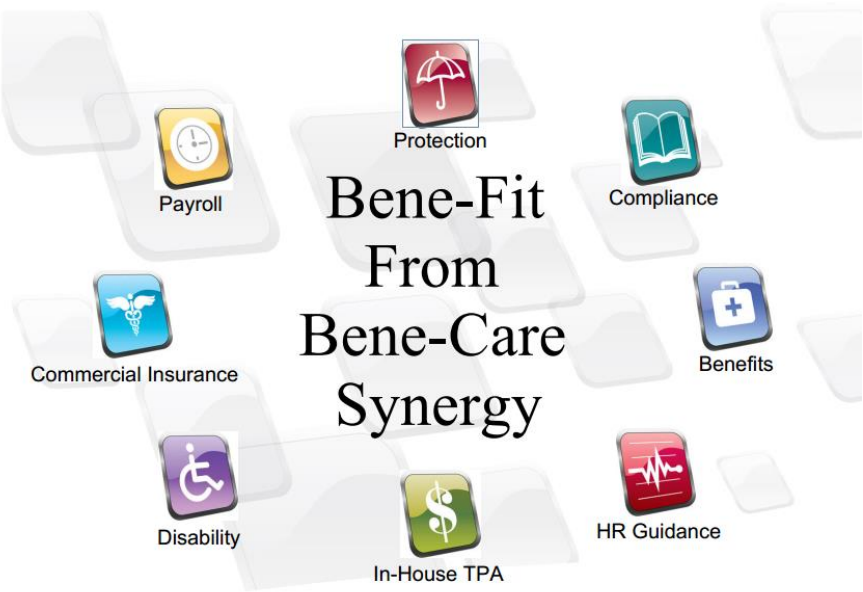
2017 Benefit Offerings Available to Small Groups (2 – 100 employees)

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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2017 1st Quarter BCBS of WNY Benefit Comparison for Small Groups

In Network:	BCBS of WNY Platinum HMO 110 Plus	BCBS of WNY Platinum PPO 843
Annual Deductible	**$0**	**$500 Single / $1,000 Family (Embedded)**
Coinsurance	**0%**	**20%**
Annual Out of Pocket Max	**$4,000 Single/ $8,000 Family (Embedded)**	**$1,000 Single/ $2,000 Family (Embedded)**
PCP Office Visit	$20 Copay	20% Coinsurance after deductible
Specialist Visit	$30 Copay	20% Coinsurance after deductible
Sick Child Visit	$20 Copay	20% Coinsurance after deductible
Radiology	$30 Copay	20% Coinsurance after deductible
Laboratory	$0 Copay	20% Coinsurance after deductible
Hospital Inpatient	$500 Copay	20% Coinsurance after deductible
Outpatient Surgery	$150 Copay	20% Coinsurance after deductible
Outpatient OT/PT/ST	$30 Copay	20% Coinsurance after deductible
Emergency Room Care	$100 Copay	20% Coinsurance after deductible
Ambulance	$100 Copay	20% Coinsurance after deductible
Urgent Care	$40 Copay	20% Coinsurance after deductible
Maternity Care	Pre/Postnatal Care: $500 Copay Delivery: $500 Copay	Pre/Postnatal Care: 20% after deductible Delivery: 20% after deductible
Outpatient Mental Health	$30 Copay	20% Coinsurance after deductible
Vision	$30 Copay	20% Coinsurance after deductible
Chiropractor	$20 Copay	20% Coinsurance after deductible
Diabetic Supplies	$30 Copay	20% Coinsurance after deductible
Prescription Coverage	**Copay per 30 Day Supply** Tier 1 $5 Tier 2 $30 Tier 3 50%	**After Deductible** Tier 1 $10 Tier 2 $30 Tier 3 50%
Out-of-Network: Deductible	$1,500 Single / $3,000 Family (Embedded)	$500 Single / $1,000 Family (Embedded)
Coinsurance	40%	40%
Annual Out of Pocket Max	$4,000 Single / $8,000 Family (Embedded)	$5,000 Single / $10,000 Family (Embedded)
Extra Benefits	$250 Wellness Card	$250 Wellness Card
Rates	**Option 1**	**Option 2**
Single	**$543.67**	**$640.83**
Subscriber and Spouse	**$1,087.34**	**$1,281.66**
Subscriber and Child(ren)	**$924.24**	**$1,089.41**
Family	**$1,549.46**	**$1,826.36**

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2017 1st Quarter BCBS of WNY Benefit Comparison for Small Groups

In Network:	BCBS of WNY Gold Complete	BCBS of WNY Gold Aqua	BCBS of WNY Gold POS 7100 NQ
Annual Deductible	**$2,500 Single/ $5,000 Family** (Aggregate)	**$1,000 Single/ $2,000 Family** (Embedded)	**$1,300 Single/ $2,600 Family** (Embedded)
Coinsurance	**0%**	**20% after 1st dollar and deductible**	**0%**
Annual Out of Pocket Max	**$2,500 Single/ $5,000 Family** (Embedded)	**$6,000 Single/ $12,000 Family** (Embedded)	**$4,000 Single/ $8,000 Family** (Embedded)
PCP Office Visit	0% after deductible	1st dollar and deductible then 20% Coinsurance	$20 Copay after deductible
Specialist Visit	0% after deductible	1st dollar and deductible then 20% Coinsurance	$40 Copay after deductible
Sick Child Visit	0% after deductible	1st dollar and deductible then 20% Coinsurance	$20 Copay after deductible
Radiology	0% after deductible	1st dollar and deductible then 20% Coinsurance	$40 after deductible
Laboratory	0% after deductible	1st dollar and deductible then 20% Coinsurance	$40 after deductible
Hospital Inpatient	0% after deductible	1st dollar then 20% Coinsurance	$500 after deductible
Outpatient Surgery	0% after deductible	1st dollar and deductible then 20% Coinsurance	$150 after deductible
Outpatient OT/PT/ST	0% after deductible	1st dollar and deductible then 20% Coinsurance	$20 Copay after deductible
Emergency Room Care	0% after deductible	1st dollar and deductible then 20% Coinsurance	$150 after deductible
Ambulance	0% after deductible	1st dollar and deductible then 20% Coinsurance	$150 Copay after deductible
Urgent Care	0% after deductible	1st dollar and deductible then 20% Coinsurance	$75 after deductible
Maternity Care	0% after deductible 0% after deductible	Pre/Postnatal Care: 1st dollar and deductible then 20% Coinsurance Delivery: 1st dollar coverage then 20% Coinsurance	Pre/Postnatal Care: $20 Copay after deductible Delivery: $500 Copay after deductible
Outpatient Mental Health	0% after deductible	1st dollar and deductible then 20% Coinsurance	$40 Copay after deductible
Vision (Child only)	0% after deductible	1st dollar and deductible then 20% Coinsurance	$40 Copay after deductible
Chiropractor	0% after deductible	1st dollar and deductible then 20% Coinsurance	$20 Copay after deductible
Diabetic Supplies	0% after deductible	1st dollar and deductible then 20% Coinsurance	$20 Copay after deductible
Prescription Coverage	**After Deductible** 0% 0% 0%	**Copay per 30 Day Supply** Tier 1 $15 Tier 2 $50 Tier 3 50%	**Copay per 30 Day Supply** Tier 1 $5 Tier 2 $30 Tier 3 $50
Out-of-Network: Deductible	$2,500 Single/ $5,000 Family (Aggregate)	$1,000 Single / $2,000 Family (Embedded)	$1,300 Single/ $2,600 Family (Aggregate)
Coinsurance	0%	50% after 1st dollar and deductible	40%
Annual Out of Pocket Max	$2,500 Single/ $5,000 Family (Embedded)	$10,000 Single / $20,000 Family (Embedded)	$10,000 Single / $20,000 Family (Embedded)
Extra Benefits	$250 Wellness Card (HSA Eligibile)	$250 Wellness Card $500/$1,000 First Dollar	$250 Wellness Card (NOT HSA ELIGIBLE)
Rates	**Option 1**	**Option 2**	**Option 3**
Single	**$446.55**	**$461.37**	**$473.41**
Subscriber and Spouse	**$893.10**	**$922.74**	**$946.82**
Subscriber and Child(ren)	**$759.14**	**$784.33**	**$804.79**
Family	**$1,272.67**	**$1,314.91**	**$1,349.22**

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2017 1st Quarter BCBS of WNY Benefit Comparison for Small Groups

In Network:	BCBS of WNY Gold POS 7100	BCBS of WNY Gold POS 7100EX	BCBS of WNY Gold PPO 7100
Annual Deductible	**$1,300 Single/ $2,600 Family** (Aggregate)	**$1,300 Single/ $2,600 Family** (Aggregate)	**$1,300 Single/ $2,600 Family** (Aggregate)
Coinsurance	**0%**	**0%**	**0%**
Annual Out of Pocket Max	**$4,000 Single/ $8,000 Family** (Embedded)	**$4,000 Single/ $8,000 Family** (Embedded)	**$4,000 Single/ $8,000 Family** (Embedded)
PCP Office Visit	$20 Copay after deductible	$20 Copay after deductible	$20 Copay after deductible
Specialist Visit	$40 Copay after deductible	$40 Copay after deductible	$40 Copay after deductible
Sick Child Visit	$20 Copay after deductible	$20 Copay after deductible	$20 Copay after deductible
Radiology	$40 after deductible	$40 after deductible	$40 after deductible
Laboratory	$40 after deductible	$40 after deductible	$40 after deductible
Hospital Inpatient	$500 after deductible	$500 after deductible	$500 after deductible
Outpatient Surgery	$150 after deductible	$150 after deductible	$150 after deductible
Outpatient OT/PT/ST	$20 Copay after deductible	$20 Copay after deductible	$20 Copay after deductible
Emergency Room Care	$150 after deductible	$150 after deductible	$150 after deductible
Ambulance	$150 Copay after deductible	$150 Copay after deductible	$150 Copay after deductible
Urgent Care	$75 after deductible	$75 after deductible	$75 after deductible
Maternity Care	Pre/Postnatal Care: $20 Copay after deductible Delivery: $500 Copay after deductible	Pre/Postnatal Care: $20 Copay after deductible Delivery: $500 Copay after deductible	Pre/Postnatal Care: $20 Copay after deductible Delivery: $500 Copay after deductible
Outpatient Mental Health	$40 Copay after deductible	$40 Copay after deductible	$40 Copay after deductible
Vision (Child only)	$40 Copay after deductible	$40 Copay after deductible	$40 Copay after deductible
Chiropractor	$20 Copay after deductible	$20 Copay after deductible	$20 Copay after deductible
Diabetic Supplies	$20 Copay after deductible	$20 Copay after deductible	$20 Copay after deductible
Prescription Coverage	**After Deductible** Tier 1 $5 Tier 2 $30 Tier 3 $50	**After Deductible** Tier 1 $5 Tier 2 $30 Tier 3 $50	**After Deductible** Tier 1 $5 Tier 2 $30 Tier 3 $50
Out-of-Network: Deductible	$1,300 Single/ $2,600 Family (Aggregate)	$1,300 Single/ $2,600 Family (Aggregate)	$1,300 Single/ $2,600 Family (Aggregate)
Coinsurance	40%	40%	40%
Annual Out of Pocket Max	$10,000 Single/ $20,000 Family (Embedded)	$10,000 Single/ $20,000 Family (Embedded)	$10,000 Single/ $20,000 Family (Embedded)
Extra Benefits	$250 Wellness Card (HSA Eligibile)	$250 Wellness Card (HSA Eligibile)	$250 Wellness Card (HSA Eligibile)
Rates	**Option 4**	**Option 5**	**Option 6**
Single	**$468.74**	**$492.86**	**$555.28**
Subscriber and Spouse	**$937.48**	**$985.72**	**$1,110.56**
Subscriber and Child(ren)	**$796.86**	**$837.87**	**$943.98**
Family	**$1,335.91**	**$1,404.65**	**$1,582.55**

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2017 1st Quarter BCBS of WNY Benefit Comparison for Small Groups

In Network:	BCBS of WNY Silver POS 7100	BCBS of WNY Silver POS 8100	BCBS of WNY Silver POS 8100EX
Annual Deductible	**$2,000 Single / $4,000 Family** (Aggregate)	**$2,000 Single/ $4,000 Family** (Aggregate)	**$2,000 Single/ $4,000 Family** (Aggregate)
Coinsurance	**0%**	**20%**	**20%**
Annual Out of Pocket Max	**$6,500 Single/ $13,000 Family** (Embedded)	**$5,500 Single/ $11,000 Family** (Embedded)	**$5,500 Single/ $11,000 Family** (Embedded)
PCP Office Visit	Deductible then $25 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Specialist Visit	Deductible then $50 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Sick Child Visit	Deductible then $25 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Radiology	Deductible then $50 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Laboratory	Deductible then $50 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Hospital Inpatient	Deductible then $750 Copay	Deductible then $750 Copay	Deductible then $750 Copay
Outpatient Surgery	Deductible then $150 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Outpatient OT/PT/ST	Deductible then $25 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Emergency Room Care	Deductible then $250 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Ambulance	Deductible then $250 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Urgent Care	Deductible then $75 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Maternity Care	Pre/Postnatal Care: Deductible then $25 Delivery: Deductible then $750 Copay	Pre/Postnatal Care: Deductible then 20% Delivery: Deductible then $750 Copay	Pre/Postnatal Care: Deductible then 20% Delivery: Deductible then $750 Copay
Outpatient Mental Health	Deductible then $50 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Vision	Deductible then $50 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Chiropractor	Deductible then $25 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Diabetic Supplies	Deductible then $25 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Prescription Coverage	**After Deductible** Tier 1 $5 Tier 2 $30 Tier 3 50%	**After Deductible** Tier 1 $5 Tier 2 $30 Tier 3 50%	**After Deductible** Tier 1 $5 Tier 2 $30 Tier 3 50%
Out-of-Network: Deductible	$2,000 Single / $4,000 Family (Aggregate)	$2,000 Single / $4,000 Family (Aggregate)	$2,000 Single / $4,000 Family
Coinsurance	40%	40%	40%
Annual Out of Pocket Max	$10,000 Single / $20,000 Family (Embedded)	$10,000 Single / $20,000 Family (Embedded)	$10,000 Single / $20,000 Family
Extra Benefits	$250 Wellness Card (HSA Eligible)	$250 Wellness Card (HSA Eligible)	$250 Wellness Card (HSA Eligible)
Rates	**Option 1**	**Option 2**	**Option 3**
Single	**$414.65**	**$415.22**	**$436.20**
Subscriber and Spouse	**$829.30**	**$830.44**	**$872.40**
Subscriber and Child(ren)	**$704.91**	**$705.87**	**$741.54**
Family	**$1,181.76**	**$1,183.38**	**$1,243.17**

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2017 1st Quarter BCBS of WNY Benefit Comparison for Small Groups

In Network:	BCBS of WNY Silver PPO 8100	BCBS of WNY Silver Blended
Annual Deductible	**$2,000 Single/ $4,000 Family (Aggregate)**	**$3,000 Single/ $6,000 Family (Embedded)**
Coinsurance	**20%**	**20%**
Annual Out of Pocket Max	**$5,500 Single/ $11,000 Family (Embedded)**	**$6,550 Single/ $13,100 Family (Embedded)**
PCP Office Visit	Deductible then 20% Coinsurance	Deductible then $25 Copay $0 for first 3 adult PCP vists after deductible
Specialist Visit	Deductible then 20% Coinsurance	Deductible then $50 Copay
Sick Child Visit	Deductible then 20% Coinsurance	Deductible then $25 Copay
Radiology	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Laboratory	Deductible then 20% Coinsurance	Deductible then $50 Copay
Hospital Inpatient	Deductible then $750 Copay	Deductible then 20% Coinsurance
Outpatient Surgery	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Outpatient OT/PT/ST	Deductible then 20% Coinsurance	Deductible then $50 Copay
Emergency Room Care	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Ambulance	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Urgent Care	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Maternity Care	Pre/Postnatal Care: Deductible then 20% Delivery: Deductible then $750 Copay	Pre/Postnatal Care: PCP/Specialist Copay Delivery: 20% Coinsurance
Outpatient Mental Health	Deductible then 20% Coinsurance	$0 Copay
Vision	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Chiropractor	Deductible then 20% Coinsurance	Deductible then $25 Copay
Diabetic Supplies	Deductible then 20% Coinsurance	Deductible then $25 Copay
Prescription Coverage	**After Deductible** Tier 1 $5 Tier 2 $30 Tier 3 50%	**After Deductible** Tier 1 $15 Tier 2 $30 Tier 3 50%
Out-of-Network: Deductibl	$2,000 Single / $4,000 Family	$3,000 Single / $6,000 Family
Coinsurance	40%	40%
Annual Out of Pocket Max	$10,000 Single / $20,000 Family	$10,000 Single / $20,000 Family
Extra Benefits	$250 Wellness Card (HSA Eligible)	$250 Wellness Card (Not HSA Eligible)
Rates	**Option 4**	**Option 5**
Single	**$490.41**	**$399.71**
Subscriber and Spouse	**$980.82**	**$799.42**
Subscriber and Child(ren)	**$833.70**	**$679.50**
Family	**$1,397.67**	**$1,139.18**

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2017 1st Quarter BCBS of WNY Benefit Comparison for Small Groups

In Network:	BCBS of WNY Bronze POS 8100EX	BCBS of WNY Bronze PPO 8100
Annual Deductible	**$5,500 Single/ $11,000 Family**	**$5,500 Single/ $11,000 Family**
Coinsurance	**20%**	**20%**
Annual Out of Pocket Max	**$6,550 Single/ $13,100 Family**	**$6,550 Single/ $13,100 Family**
PCP Office Visit	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Specialist Visit	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Sick Child Visit	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Radiology	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Laboratory	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Hospital Inpatient	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Outpatient Surgery	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Outpatient OT/PT/ST	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Emergency Room Care	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Ambulance	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Urgent Care	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Maternity Care	Pre/Postnatal Care: Deductible then 20% Coinsurance Delivery: Deductible then 20% Coinsurance	Pre/Postnatal Care: Deductible then 20% Coinsurance Delivery: Deductible then 20% Coinsurance
Outpatient Mental Health	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Vision	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Chiropractor	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Diabetic Supplies	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Prescription Coverage	**After Deductible** Tier 1 $15 Tier 2 $50 Tier 3 50%	**After Deductible** Tier 1 $15 Tier 2 $50 Tier 3 50%
Out-of-Network: Deductible	**$5,500 Single/ $11,000 Family**	**$5,500 Single/ $11,000 Family**
Coinsurance	**40%**	**40%**
Annual Out of Pocket Max	**$10,000 Single / $20,000 Family**	**$10,000 Single / $20,000 Family**
Extra Benefits	$250 Wellness Card (HSA Eligibile)	$250 Wellness Card (HSA Eligibile)
Rates	**Option 1**	**Option 2**
Single	**$401.09**	**$450.54**
Subscriber and Spouse	**$802.18**	**$901.08**
Subscriber and Child(ren)	**$681.85**	**$765.92**
Family	**$1,143.10**	**$1,284.04**

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2017 1st Quarter BCBS of WNY Benefit Comparison for Small Groups

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 (Embedded)**	**$2,000 Single/ $4,000 Family (Embedded)**	**$4,000 Single/ $8,000 Family (Embedded)**
Coinsurance	**0%**	**0%**	**0%**	**50%**
Annual Out of Pocket Max	**$2,000 Single / $4,000 Family (Embedded)**	**$4,000 Single/ $8,000 Family (Embedded)**	**$6,750 Single/ $13,500 Family (Embedded)**	**$7,150Single/ $14,300 Family (Embedded)**
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
Maternity Care	Pre/Postnatal Care: $15 Copay Delivery: $500 Copay	Pre/Postnatal Care: Deductible then $25 Copay Delivery: Deductible then $1,000 Copay	Pre/Postnatal Care: Deductible then $30 Copay Delivery: Deductible then $1,500 Copay	Pre/Postnatal Care: Deductible then 50% Coinsurance Delivery: Deductible then 50% Coinsurance
Outpatient Mental Health	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance
Vision	$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	**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
Out-of-Network: Deductible	$5,000 Single / $10,000 Family (Embedded)	$5,000 Single / $10,000 Family (Embedded)	$5,000 Single / $10,000 Family (Embedded)	$5,000 Single / $10,000 Family (Embedded)
Coinsurance	50%	50%	50%	50%
Annual Out of Pocket Max	$10,000 Single / $20,000 Family	$10,000 Single / $20,000 Family (Embedded)	$10,000 Single / $20,000 Family (Embedded)	$10,000 Single / $20,000 Family (Embedded)
Extra Benefits	$250 Wellness Card	$250 Wellness Card	$250 Wellness Card	$250 Wellness Card
Rates	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Single	**$562.13**	**$490.51**	**$430.53**	**$364.00**
Subscriber and Spouse	**$1,124.26**	**$981.02**	**$861.06**	**$728.00**
Subscriber and Child(ren)	**$955.62**	**$833.87**	**$731.91**	**$618.80**
Family	**$1,602.07**	**$1,397.95**	**$1,227.01**	**$1,037.40**

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11/4/2016

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2017 1st Quarter BCBS of WNY Benefit Comparison for Small Groups

	BCBS of WNY - Silver Align		BCBS of WNY - Bronze Align	
In Network:	**Optimum Choice**	**Flexible Choice**	**Optimum Choice**	**Flexible Choice**
Annual Deductible	**$1,300 Single/ $2,600 Family** (Aggregate)	**$3,500 Single/ $7,000 Family** (Aggregate)	**$7,000 Single/ $14,000 Family** (Embedded)	**$7,150 Single/ $14,300 Family** (Embedded)
Coinsurance	**30%**	**50%**	**50%**	**0%**
Annual Out of Pocket Max	**$6,550 Single / $13,100 Family** (Embedded)		**$7,150 Single / $14,300 Family** (Embedded)	
PCP Office Visit	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Specialist Visit	Deductible then $50 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Sick Child Visit	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Radiology	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Laboratory	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Hospital Inpatient	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Outpatient Surgery	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Outpatient OT/PT/ST	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Emergency Room Care	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Ambulance	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Urgent Care	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Maternity Care	Pre/Postnatal Care: Deductible then $30 Copay Delivery: Deductible then 30% Coinsurance	Pre/Postnatal Care: Deductible then 50% Coinsurance Delivery: Deductible then 50% Coinsurance	Pre/Postnatal Care: Deductible then 50% Coinsurance Delivery: Deductible then 50% Coinsurance	Pre/Postnatal Care: Deductible then 0% Coinsurance Delivery: Deductible then 0% Coinsurance
Outpatient Mental Health	Covered in Full	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Vision	Deductible then $50 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Chiropractor	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Diabetic Supplies	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Prescription Coverage	**After Deductible** Tier 1 $5 Tier 2 $30 Tier 3 50%		**After Deductible** Tier 1 $10 Tier 2 50% Tier 3 50%	
Out-of-Network: Deductible **Coinsurance** **Annual Out of Pocket Max**	$3,500 Single / $7,000 Family (Aggregate) 50% $10,000 Single / $20,000 Family (Embedded)		$7,150 Single / $14,300 Family (Embedded) 50% $10,000 Single / $20,000 Family (Embedded)	
Extra Benefits	$250 Wellness Card (HSA Eligibile)		$250 Wellness Card (HSA Eligibile)	
Rates	**Option 3**		**Option 4**	
Single	**$392.06**		**$349.40**	
Subscriber and Spouse	**$784.12**		**$698.80**	
Subscriber and Child(ren)	**$666.50**		**$593.98**	
Family	**$1,117.37**		**$995.80**	

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2017 1st Quarter Independent Health Benefit Comparison for Small Groups

In Network:	Independent Health FlexFit Platinum	Independent Health iDirect Platinum
Annual Deductible	**$0**	**$1,000 Single/ $2,000 Family**
Coinsurance	**0%**	**0%**
Annual Out of Pocket Max	**$5,000 Single/ $10,000 Family**	**$1,000 Single/ $2,000 Family**
PCP Office Visit	$10 Copay	Deductible then $0 Copay
Specialist Visit	$30 Copay	Deductible then $0 Copay
Sick Child Visit	$10 Copay	Deductible then $0 Copay
Radiology	$30 Copay	Deductible then $0 Copay
Laboratory	$10 Copay	Deductible then $0 Copay
Hospital Inpatient	$500 Copay	Deductible then $0 Copay
Outpatient Surgery	$150 Copay	Deductible then $0 Copay
Outpatient OT/PT/ST	$30 Copay	Deductible then $0 Copay
Emergency Room Care	$150 Copay	Deductible then $0 Copay
Ambulance	$150 Copay	Deductible then $0 Copay
Urgent Care	$75 Copay	Deductible then $0 Copay
Maternity Care	Pre/Postnatal Care: Covered in Full Delivery: $500 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $0 Copay
Outpatient Mental Health	$30 Copay	Deductible then $0 Copay
Vision	$30 Copay	Deductible then $0 Copay
Chiropractor	$30 Copay	Deductible then $0 Copay
Diabetic Supplies	$10 Copay	Deductible then $0 Copay
Prescription Coverage	**Copay per 30 Day Supply** Tier 1 $4 Tier 2 $30 Tier 3 $100	**After Deductible** Tier 1 $0 Tier 2 $0 Tier 3 $0
Out-of-Network: Deductible	$2,000 Single/ $4,000 Family	$2,000 Single/ $4,000 Family
Coinsurance	40%	40%
Annual Out of Pocket Max	$6,750 Single/ $13,500 Family	$6,750 Single/ $13,500 Family
Extra Benefits	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit
Rates	**Option 1**	**Option 2**
Single	**$550.49**	**$513.68**
Subscriber and Spouse	**$1,100.98**	**$1,027.36**
Subscriber and Child(ren)	**$935.83**	**$873.26**
Family	**$1,568.90**	**$1,463.99**

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In Network:	Independent Health iDirect Gold HSAQ	Independent Health iDirect Gold Copay	Independent Health iDirect Gold Copay HSAQ	Independent Health Max Gold
Annual Deductible **Coinsurance** **Annual Out of Pocket Max**	**$2,100 Single/ $4,200 Family** **0%** **$2,100 Single/ $4,200 Family**	**$750 Single/ $1,500 Family** **0%** **$6,350 Single/ $12,700 Family**	**$1,400 Single/ $2,800 Family** **0%** **$6,000 Single/ $12,000 Family**	**$1,000 Single/ $2,000 Family** **20%** **$6,350 Single/ $12,700 Family**
PCP Office Visit	Deductible then $0 Copay	$15 Copay	Deductible then $15 Copay	$15 Copay
Specialist Visit	Deductible then $0 Copay	$45 Copay	Deductible then $40 Copay	$40 Copay
Sick Child Visit	Deductible then $0 Copay	$15 Copay	Deductible then $15 Copay	$15 Copay
Radiology	Deductible then $0 Copay	Deductible then $45 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance
Laboratory	Deductible then $0 Copay	Deductible then $25 Copay	Deductible then $15 Copay	Deductible then 20% Coinsurance
Hospital Inpatient	Deductible then $0 Copay	Deductible then $1,000 Copay	Deductible then $500 Copay	Deductible then 20% Coinsurance
Outpatient Surgery	Deductible then $0 Copay	Deductible then $150 Copay	Deductible then $100 Copay	Deductible then 20% Coinsurance
Outpatient OT/PT/ST	Deductible then $0 Copay	Deductible then $45 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance
Emergency Room Care	Deductible then $0 Copay	$150 Copay	Deductible then $100 Copay	Deductible then 20% Coinsurance
Ambulance	Deductible then $0 Copay	$150 Copay	Deductible then $100 Copay	Deductible then 20% Coinsurance
Urgent Care	Deductible then $0 Copay	$75 Copay	Deductible then $75 Copay	$75 Copay
Maternity Care	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $0 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $1,000 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $500 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then 20% Coinsurance
Outpatient Mental Health	Deductible then $0 Copay	Deductible then $45 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance
Vision	Deductible then $0 Copay	Deductible then $45 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance
Chiropractor	Deductible then $0 Copay	Deductible then $45 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance
Diabetic Supplies	Deductible then $0 Copay	Deductible then $20 Copay	Deductible then $15 Copay	Deductible then 20% Coinsurance
Prescription Coverage	**After Deductible** Tier 1 $0 Tier 2 $0 Tier 3 $0	**Copay per 30 Day Supply** Tier 1 $4 Tier 2 $30 Tier 3 50%	**After Deductible** Tier 1 $4 Tier 2 $30 Tier 3 50%	**After Deductible (except Tier 1)** Tier 1 $4 Tier 2 $45 Tier 3 50%
Out-of-Network: Deductible **Coinsurance** **Annual Out of Pocket Max**	$2,500 Single/ $5,000 Family 40% $10,000 Single/ $20,000 Family	$2,500 Single/ $5,000 Family 40% $10,000 Single/ $20,000 Family	$2,500 Single/ $5,000 Family 40% $10,000 Single/ $20,000 Family	$2,500 Single/ $5,000 Family 40% $10,000 Single/ $20,000 Family
Extra Benefits	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit
Rates	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Single	**$435.24**	**$486.66**	**$435.05**	**$468.89**
Subscriber and Spouse	**$870.48**	**$973.32**	**$870.10**	**$937.78**
Subscriber and Child(ren)	**$739.91**	**$827.32**	**$739.59**	**$797.11**
Family	**$1,240.43**	**$1,386.98**	**$1,239.89**	**$1,336.34**

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2017 1st Quarter Independent Health Benefit Comparison for Small Groups

In Network:	Independent Health iDirect Silver Copay	Independent Health iDirect Silver Copay HSAQ	Independent Health iDirect Silver Coinsurance HSAQ	Independent Health Max Silver
Annual Deductible	**$1,700 Single/ $3,400 Family**	**$1,750 Single/ $3,500 Family**	**$2,000 Single/ $4,000 Family**	**$2,350 Single/ $4,700 Family**
Coinsurance	**0%**	**0%**	**20%**	**0%**
Annual Out of Pocket Max	**$7,100 Single/ $14,200 Family**	**$6,550 Single/ $13,100 Family**	**$6,200 Single/ $12,400 Family**	**$7,100 Single/ $14,200 Family**
PCP Office Visit	Deductible then $30 Copay	Deductible then $35 Copay	Deductible then 20% Coinsurance	$35 Copay
Specialist Visit	Deductible then $50 Copay	Deductible then $60 Copay	Deductible then 20% Coinsurance	Deductible then $50 Copay
Sick Child Visit	Deductible then $30 Copay	Deductible then $35 Copay	Deductible then 20% Coinsurance	$35 Copay
Radiology	Deductible then $50 Copay	Deductible then $60 Copay	Deductible then 20% Coinsurance	Deductible then $50 Copay
Laboratory	Deductible then $30 Copay	Deductible then $40 Copay	Deductible then 20% Coinsurance	Deductible then $35 Copay
Hospital Inpatient	Deductible then $1,000 Copay	Deductible then $1,000 Copay	Deductible then 20% Coinsurance	Deductible then $1,000 Copay
Outpatient Surgery	Deductible then $150 Copay	Deductible then $200 Copay	Deductible then 20% Coinsurance	Deductible then $200 Copay
Outpatient OT/PT/ST	Deductible then $50 Copay	Deductible then $50 Copay	Deductible then 20% Coinsurance	Deductible then $50 Copay
Emergency Room Care	Deductible then $200 Copay	Deductible then $250 Copay	Deductible then 20% Coinsurance	Deductible then $225 Copay
Ambulance	Deductible then $200 Copay	Deductible then $250 Copay	Deductible then 20% Coinsurance	Deductible then $200 Copay
Urgent Care	Deductible then $75 Copay	Deductible then $75 Copay	Deductible then 20% Coinsurance	$50 Copay
Maternity Care	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $1,000 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $1,000 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then 20% Coinsurance	Pre/Postnatal Care: Covered in Full Delivery: Deductible then $1,000 Copay
Outpatient Mental Health	Deductible then $50 Copay	Deductible then $60 Copay	Deductible then 20% Coinsurance	Deductible then $50 Copay
Vision	Deductible then $50 Copay	Deductible then $60 Copay	Deductible then 20% Coinsurance	Deductible then $50 Copay
Chiropractor	Deductible then $50 Copay	Deductible then $60 Copay	Deductible then 20% Coinsurance	Deductible then $50 Copay
Diabetic Supplies	Deductible then $30 Copay	Deductible then $35 Copay	Deductible then 20% Coinsurance	Deductible then $35 Copay
Prescription Coverage	**Copay per 30 Day Supply** Tier 1 $10 Tier 2 $50 Tier 3 50%	**After Deductible** Tier 1 $10 Tier 2 $50 Tier 3 50%	**After Deductible** 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	$3,000 Single/ $6,000 Family	$3,000 Single/ $6,000 Family	$3,000 Single/ $6,000 Family	$3,000 Single/ $6,000 Family
Coinsurance	40%	40%	40%	40%
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	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit
Rates	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Single	**$423.49**	**$392.82**	**$387.11**	**$416.71**
Subscriber and Spouse	**$846.98**	**$785.64**	**$774.22**	**$833.42**
Subscriber and Child(ren)	**$719.93**	**$667.79**	**$658.09**	**$708.41**
Family	**$1,206.95**	**$1,119.54**	**$1,103.26**	**$1,187.62**

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2017 1st Quarter Independent Health Benefit Comparison for Small Groups

In Network:	Independent Health iDirect Bronze HSAQ	Independent Health iDirect Bronze MV HSAQ (Minimum Value)
Annual Deductible	**$4,425 Single/ $8,850 Family**	**$6,550 Single/ $13,100 Family**
Coinsurance	**50%**	**0%**
Annual Out of Pocket Max	**$6,550 Single/ $13,100 Family**	**$6,550 Single/ $13,100 Family**
PCP Office Visit	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Specialist Visit	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Sick Child Visit	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Radiology	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Laboratory	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Hospital Inpatient	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Outpatient Surgery	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Outpatient OT/PT/ST	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Emergency Room Care	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Ambulance	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Urgent Care	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Maternity Care	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	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Vision	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Chiropractor	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Diabetic Supplies	Deductible then 50% Coinsurance	Deductible then 0% Coinsurance
Prescription Coverage	**After Deductible** Tier 1 50% Tier 2 50% Tier 3 50%	**After Deductible** Tier 1 0% Tier 2 0% Tier 3 0%
)ut-of-Network: Deductible **Coinsurance** **Annual Out of Pocket Max**	$5,000 Single/ $10,000 Family 50% $10,000 Single/ $20,000 Family	$6,550 Single/ $13,100 Family 50% $10,000 Single/ $20,000 Family
Extra Benefits	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit
Rates	**Option 1**	**Option 2**
Single	**$328.11**	**$311.19**
Subscriber and Spouse	**$656.22**	**$622.38**
Subscriber and Child(ren)	**$557.79**	**$529.02**
Family	**$935.11**	**$886.89**

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In Network:	Independent Health Standard Platinum	Independent Health Standard Gold	Independent Health Standard Silver	Independent Health Standard Bronze
Annual Deductible	**$0**	**$600 Single/ $1,200 Family**	**$2,000 Single/ $4,000 Family**	**$4,000 Single/ $8,000 Family**
Coinsurance	**0%**	**0%**	**0%**	**50%**
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 $25 Copay	Deductible then $25 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 $1,000 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
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
Outpatient Mental Health	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance
Vision	$35 Copay	Deductible then $40 Copay	Deductible then $50 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	**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
ut-of-Network: Deductible **Coinsurance** **Annual Out of Pocket Max**	$2,000 Single/ $4,000 Family 40% $6,750 Single/ $13,500 Family	$2,500 Single/ $5,000 Family 40% $10,000 Single/ $20,000 Family	$3,000 Single/ $6,000 Family 40% $10,000 Single/ $20,000 Family	$5,000 Single/ $10,000 Family 50% $10,000 Single/ $20,000 Family
Extra Benefits	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit
Rates	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Single	**$555.41**	**$487.29**	**$424.43**	**$331.94**
Subscriber and Spouse	**$1,110.82**	**$974.58**	**$848.86**	**$663.88**
Subscriber and Child(ren)	**$944.20**	**$828.39**	**$721.53**	**$564.30**
Family	**$1,582.92**	**$1,388.78**	**$1,209.63**	**$946.03**

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In Network:	Independent Health NY/PA Gold	Independent Health NY/PA Silver
Annual Deductible	**$1,000 Single/ $2,000 Family**	**$2,000 Single/ $4,000 Family**
Coinsurance	**20%**	**20%**
Annual Out of Pocket Max	**$5,400 Single/ $10,800 Family**	**$6,200 Single/ $12,400 Family**
PCP Office Visit	20% Coinsurance	Deductible then 20% Coinsurance
Specialist Visit	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Sick Child Visit	20% Coinsurance	Deductible then 20% Coinsurance
Radiology	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Laboratory	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Hospital Inpatient	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Outpatient Surgery	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Outpatient OT/PT/ST	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Emergency Room Care	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Ambulance	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Urgent Care	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Maternity Care	Pre/Postnatal Care: Covered in Full Delivery: Deductible then 20% Coinsurance	Pre/Postnatal Care: Covered in Full Delivery: Deductible then 20% Coinsurance
Outpatient Mental Health	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Vision	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Chiropractor	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Diabetic Supplies	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Prescription Coverage	**Copay per 30 Day Supply** Tier 1 $4 Tier 2 $30 Tier 3 50%	**After Deductible** Tier 1 $4 Tier 2 $30 Tier 3 50%
Out-of-Network: Deductible	$2,500 Single/ $5,000 Family	$3,000 Single/ $6,000 Family
Coinsurance	40%	40%
Annual Out of Pocket Max	$10,000 Single/ $20,000 Family	$10,000 Single/ $20,000 Family
Extra Benefits	Health Extras or Nutrition Benefit	Health Extras or Nutrition Benefit
Rates	**Option 1**	**Option 2**
Single	**$490.61**	**$408.39**
Subscriber and Spouse	**$981.22**	**$816.78**
Subscriber and Child(ren)	**$834.04**	**$694.26**
Family	**$1,398.24**	**$1,163.91**

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Benefits Advocate

2017 1st Quarter Independent Health Benefit Comparison for Small Groups

In Network:	Independent Health Passport Plan Platinum	Independent Health Passport Plan Gold	Independent Health Passport Plan Silver HSAQ	Independent Health Passport Plan Bronze HSAQ
Annual Deductible	**$0**	**$1,000 Single/ $2,000 Family**	**$2,000 Single/ $4,000 Family**	**$4,425 Single/ $8,850 Family**
Coinsurance	**0%**	**20%**	**20%**	**50%**
Annual Out of Pocket Max	**$5,000 Single/ $10,000 Family**	**$5,400 Single/ $10,800 Family**	**$6,200 Single/ $12,400 Family**	**$6,550 Single/ $13,100 Family**
PCP Office Visit	$30 Copay	20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Specialist Visit	$50 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Sick Child Visit	$30 Copay	20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Radiology	$30 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Laboratory	$10 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Hospital Inpatient	$500 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Outpatient Surgery	$150 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Outpatient OT/PT/ST	$30 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Emergency Room Care	$150 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Ambulance	$150 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Urgent Care	$75 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Maternity Care	Pre/Postnatal Care: Covered in Full Delivery: $500 Copay	Pre/Postnatal Care: Covered in Full Delivery: Deductible then 20% Coinsurance	Pre/Postnatal Care: Covered in Full Delivery: Deductible then 20% Coinsurance	Pre/Postnatal Care: Covered in Full Delivery: Deductible then 50% Coinsurance
Outpatient Mental Health	$50 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Vision	$50 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Chiropractor	$50 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Diabetic Supplies	$30 Copay	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
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** Tier 1 $4 Tier 2 $30 Tier 3 50%	**After Deductible** Tier 1 50% Tier 2 50% Tier 3 50%
ut-of-Network: Deductible	$2,000 Single/ $4,000 Family	$2,500 Single/ $5,000 Family	$3,000 Single/ $6,000 Family	$5,000 Single/ $10,000 Family
Coinsurance	40%	40%	40%	50%
Annual Out of Pocket Max	$6,750 Single/ $13,500 Family	$10,000 Single/ $20,000 Family	$10,000 Single/ $20,000 Family	$10,000 Single/ $20,000 Family
Extra Benefits	NY Standard Gym Benefit	NY Standard Gym Benefit	NY Standard Gym Benefit	Health Extras or Nutrition Benefit
Rates	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Single	**$1,039.87**	**$827.96**	**$694.03**	**$578.75**
Subscriber and Spouse	**$2,079.74**	**$1,655.92**	**$1,388.06**	**$1,157.50**
Subscriber and Child(ren)	**$1,767.78**	**$1,407.53**	**$1,179.85**	**$983.88**
Family	**$2,963.63**	**$2,359.69**	**$1,977.99**	**$1,649.44**

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2017 1st Quarter Independent Health Benefit Comparison for Small Groups

In Network:	Independent Health Choice Plus Platinum	Independent Health Choice Plus Gold	Independent Health Choice Plus Silver
Annual Deductible	**A: $0** **B: $1,000 Single/ $2,000 Family**	**A: $750 Single/ $1,500 Family** **B: $2,000 Single/ $4,000 Family**	**A: $1,750 Single/ $3,500 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 / $10,000** **B: $6,450 / $12,900**	**A: $6,350 Single/ $12,700 Family** **B: $6,850 Single/ $13,700 Family**	**A: $6,550 Single/ $13,100 Family** **B: $6,550 Single/ $13,100 Family**
PCP Office Visit	A: $10 Copay B: Deductible then 40% Coinsurance	A: $15 Copay B: Deductible then 50% Coinsurance	A: Deductible then $35 Copay B: Deductible then 50% Coinsurance
Specialist Visit	A: $30 Copay B: Deductible then 40% Coinsurance	A: $45 Copay B: Deductible then 50% Coinsurance	A: Deductible then $60 Copay B: Deductible then 50% Coinsurance
Sick Child Visit	A: $10 Copay B: Deductible then 40% Coinsurance	A: $20 Copay B: Deductible then 50% Coinsurance	A: Deductible then $35 Copay B: Deductible then 50% Coinsurance
Radiology	A: $30 Copay B: Deductible then 40% Coinsurance	A: Deductible then $40 Copay B: Deductible then 50% Coinsurance	A: Deductible then $60 Copay B: Deductible then 50% Coinsurance
Laboratory	A: $0 Copay B: Deductible then 40% Coinsurance	A: Deductible then $20 Copay B: Deductible then 50% Coinsurance	A: Deductible then $40 Copay B: Deductible then 50% Coinsurance
Hospital Inpatient	A: $500 Copay B: Deductible then 40% Coinsurance	A: Deductible then $1,000 Copay B: Deductible then 50% Coinsurance	A: Deductible then $1,000 Copay B: Deductible then 50% Coinsurance
Outpatient Surgery	A: $150 Copay B: Deductible then 40% Coinsurance	A: Deductible then $150 Copay B: Deductible then 50% Coinsurance	A: Deductible then $200 Copay B: Deductible then 50% Coinsurance
Outpatient OT/PT/ST	A: $30 Copay B: Deductible then 40% Coinsurance	A: Deductible then $0 Copay B: Deductible then 50% Coinsurance	A: Deductible then $50 Copay B: Deductible then 50% Coinsurance
Emergency Room Care	$150 Copay	$150 Copay	Deductible then $250 Copay
Ambulance	$150 Copay	$150 Copay	Deductible then $250 Copay
Urgent Care	A: $75 Copay B: Deductible then 40% Coinsurance	A: $75 Copay B: Deductible then 50% Coinsurance	A: Deductible then $75 Copay B: Deductible then 50% Coinsurance
Maternity Care	Pre/Postnatal Care: Covered in Full Delivery: A: $500 Copay B: Deductible then 40% Coinsurance	Pre/Postnatal Care: Covered in Full Delivery: A: Deductible then $1,000 Copay A: $500 Copay B: Deductible then 40% Coinsurance	Pre/Postnatal Care: Covered in Full Delivery: A: Deductible then $1,000 Copay A: $500 Copay B: Deductible then 40% Coinsurance
Outpatient Mental Health	A: $30 Copay B: Deductible then 40% Coinsurance	A: Deductible then $40 Copay B: Deductible then 50% Coinsurance	A: Deductible then $50 Copay B: Deductible then 50% Coinsurance
Vision	A: $30 Copay B: Deductible then 40% Coinsurance	A: Deductible then $40 Copay B: Deductible then 50% Coinsurance	A: Deductible then $50 Copay B: Deductible then 50% Coinsurance
Chiropractor	A: $30 Copay B: Deductible then 40% Coinsurance	A: Deductible then $40 Copay B: Deductible then 50% Coinsurance	A: Deductible then $50 Copay B: Deductible then 50% Coinsurance
Diabetic Supplies	A: $10 Copay B: Deductible then 40% Coinsurance	A: Deductible then $15 Copay B: Deductible then 50% Coinsurance	A: Deductible then $30 Copay B: Deductible then 50% Coinsurance
Prescription Coverage	**Copay per 30 Day Supply** Tier 1 $4 Tier 2 $30 Tier 3 $100	**Copay per 30 Day Supply** Tier 1 $4 Tier 2 $30 Tier 3 50%	**After Deductible** 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% $6,750 Single/ $13,500 Family	$2,500 Single/ $5,000 Family 50% $10,000 Single/ $20,000 Family	$5,000 Single/ $10,000 Family 50% $10,000 Single/ $20,000 Family
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	**$528.45**	**$457.69**	**$377.87**
Subscriber and Spouse	**$1,056.90**	**$915.38**	**$755.74**
Subscriber and Child(ren)	**$898.37**	**$778.07**	**$642.38**
Family	**$1,506.08**	**$1,304.42**	**$1,076.93**

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2017 1st Quarter Univera Comparison for Small Groups

In Network:	Univera Access Platinum 1	Univera Preferred Access Platinum (Erie County Only)	Univera Access Platinum 2 (All Other Counties)
Annual Deductible	**$0**	**$0**	**$0**
Coinsurance	**0%**	**0%**	**0%**
Annual Out of Pocket Max	**$4,500 Single / $9,000 Family**	**$5,500 Single / $11,000 Family**	**$5,500 Single / $11,000 Family**
PCP Office Visit	$5 Copay	$5 Copay	$5 Copay
Specialist Visit	$45 Copay	$30 Copay	$30 Copay
Sick Child Visit	$5 Copay	$5 Copay	$5 Copay
Radiology	$45 Copay	$30 Copay	$30 Copay
Laboratory	$20 Copay	$10 Copay	$10 Copay
Hospital Inpatient	$500 Copay	$500 Copay	$500 Copay
Outpatient Surgery	$100 Copay	$150 Copay	$150 Copay
Outpatient OT/PT/ST	$45 Copay	$30 Copay	$30 Copay
Emergency Room Care	$100 Copay	$150 Copay	$150 Copay
Ambulance	$100 Copay	$150 Copay	$150 Copay
Urgent Care	$45 Copay	$30 Copay	$30 Copay
Maternity Care	Pre/Postnatal Care: $0 Copay (Cost Share May Apply) Delivery: $500 Copay	Pre/Postnatal Care: $0 Copay (Cost Share May Apply) Delivery: $500 Copay	Pre/Postnatal Care: $0 Copay (Cost Share May Apply) Delivery: $500 Copay
Outpatient Mental Health	$45 Copay	$30 Copay	$30 Copay
Vision	$45 Copay	$30 Copay	$30 Copay
Chiropractor	$45 Copay	$30 Copay	$30 Copay
Prescription Coverage	**Copay per 30 Day Supply** Tier 1 $5 Tier 2 $30 Tier 3 50%	**Copay per 30 Day Supply** Tier 1 $5 Tier 2 $45 Tier 3 $50	**Copay per 30 Day Supply** Tier 1 $5 Tier 2 $45 Tier 3 $50
Out-of-Network			
Deductible **Coinsurance** **Annual Out of Pocket Max**	$2,000 Single / $4,000 Family 40% $9,000 Single / $18,000 Family	$2,000 Single / $4,000 Family 40% $11,000 Single / $22,000 Family	$2,000 Single / $4,000 Family 40% $11,000 Single / $22,000 Family
Extra Benefits	Exercise Rewards	Exercise Rewards	Exercise Rewards
Rates	**Option 1**	**Option 2**	**Option 3**
Single Subscriber and Spouse Subscriber and Child(ren) Family	**$636.82** **$1,273.65** **$1,082.60** **$1,814.95**	**$611.41** **$1,222.82** **$1,039.40** **$1,742.52**	**$651.96** **$1,303.92** **$1,108.33** **$1,858.10**

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2017 1st Quarter Univera Comparison for Small Groups

In Network:	Univera Access Gold 1	Univera Preferred Access Gold (Erie County Only)	Univera Access Gold 2 (All Other Counties)
Annual Deductible	**$1,300 Single / $2,600 Family**	**$750 Single / $1,500 Fmaily**	**$750 Single / $1,500 Family**
Coinsurance	**Applicable where noted**	**Applicable where noted**	**Applicable where noted**
Annual Out of Pocket Max	**$4,000 Single / $8,000 Family**	**$6,350 Single / $12,700 Family**	**$6,350 Single / $12,700 Family**
PCP Office Visit	Deductible then $5 Copay	Deductible then $5 Copay	Deductible then $5 Copay
Specialist Visit	Deductible then $35 Copay	Deductible then $45 Copay	Deductible then $45 Copay
Sick Child Visit	Deductible then $5 Copay	Deductible then $5 Copay	Deductible then $5 Copay
Radiology	Deductible then $35 Copay	Deductible then $45 Copay	Deductible then $45 Copay
Laboratory	Deductible then $35 Copay	Deductible then $25 Copay	Deductible then $25 Copay
Hospital Inpatient	Deductible then $500 Copay	Deductible then $1000 Copay	Deductible then $1000 Copay
Outpatient Surgery	Deductible then $150 Copay	Deductible then $150 Copay	Deductible then $150 Copay
Outpatient OT/PT/ST	Deductible then $35 Copay	Deductible then $45 Copay	Deductible then $45 Copay
Emergency Room Care	Deductible then $150 Copay	Deductible then $150 Copay	Deductible then $150 Copay
Ambulance	Deductible then $150 Copay	Deductible then $150 Copay	Deductible then $150 Copay
Urgent Care	Deductible then $35 Copay	Deductible then $45 Copay	Deductible then $45 Copay
Maternity Care	Pre/Postnatal Care: Deductible then $0 Copay (cost share may apply) Delivery: Deductible then $500 Copay	Pre/Postnatal Care: Deductible then $0 Copay (cost share may apply) Delivery: Deductible then $1,000 Copay	Pre/Postnatal Care: Deductible then $0 Copay (cost share may apply) Delivery: Deductible then $1,000 Copay
Outpatient Mental Health	Deductible then $35 Copay	Deductible then $45 Copay	Deductible then $45 Copay
Vision	Deductible then $35 Copay	Deductible then $45 Copay	Deductible then $45 Copay
Chiropractor	Deductible then $35 Copay	Deductible then $45 Copay	Deductible then $45 Copay
Prescription Coverage	**After Deductible (except preventive drugs)** Tier 1 $5 Tier 2 $45 Tier 3 $50	**Copay per 30 Day Supply** Tier 1 $5 Tier 2 $50 Tier 3 50%	**Copay per 30 Day Supply** Tier 1 $5 Tier 2 $50 Tier 3 50%
Out-of-Network			
Deductible	$2,600 Single / $5,200 Family	$1,500 Single / $3,000 Family	$1,500 Single / $3,000 Family
Coinsurance	40%	40%	40%
Annual Out of Pocket Max	$8,000 Single / $16,000 Family	$12,700 Single / $25,400 Family	$12,700 / $25,400
Extra Benefits	HSA Eligible & Exercise Rewards	Exercise Rewards	Exercise Rewards
Rates	**Option 1**	**Option 2**	**Option 3**
Single	**$566.49**	**$521.57**	**$556.17**
Subscriber and Spouse	**$1,132.98**	**$1,043.15**	**$1,112.35**
Subscriber and Child(ren)	**$963.03**	**$886.68**	**$945.50**
Family	**$1,614.50**	**$1,486.48**	**$1,585.10**

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2017 1st Quarter Univera Comparison for Small Groups

In Network:	Univera Access Silver 1	Univera Preferred Access Silver (Erie County Only)	Univera Access Silver 2 (All Other Counties)
Annual Deductible	**$2,000 Single/ $4,000 Family**	**$2,000 Single / $4,000 Family**	**$2,000 Single / $4,000 Family**
Coinsurance	**20%**	**Applicable where noted**	**Applicable where noted**
Annual Out of Pocket Max	**$6,550 Single / $13,100 Family**	**$6,850 Single / $13,700 Family**	**$6,850 Single / $13,700 Family**
PCP Office Visit	Deductible then 20% Coinsurance	Deductible then $5 Copay	Deductible then $5 Copay
Specialist Visit	Deductible then 20% Coinsurance	Deductible then $50 Copay	Deductible then $50 Copay
Sick Child Visit	Deductible then 20% Coinsurance	Deductible then $5 Copay	Deductible then $5 Copay
Radiology	Deductible then 20% Coinsurance	Deductible then $50 Copay	Deductible then $50 Copay
Laboratory	Deductible then 20% Coinsurance	Deductible then $30 Copay	Deductible then $30 Copay
Hospital Inpatient	Deductible then 20% Coinsurance	Deductible then $1000 Copay	Deductible then $1000 Copay
Outpatient Surgery	Deductible then 20% Coinsurance	Deductible then $200 Copay	Deductible then $200 Copay
Outpatient OT/PT/ST	Deductible then 20% Coinsurance	Deductible then $50 Copay	Deductible then $50 Copay
Emergency Room Care	Deductible then 20% Coinsurance	Deductible then $200 Copay	Deductible then $200 Copay
Ambulance	Deductible then 20% Coinsurance	Deductible then $200 Copay	Deductible then $200 Copay
Urgent Care	Deductible then 20% Coinsurance	Deductible then $50 Copay	Deductible then $50 Copay
Maternity Care	Pre/Postnatal Care: Deductible then $0 Copay (cost share may apply) Delivery: Deductible then 20% Coinsurance	Pre/Postnatal Care: Deductible then $0 Copay (cost share may apply) Delivery: Deductible then $1,000 Copay	Pre/Postnatal Care: Deductible then $0 Copay (cost share may apply) Delivery: Deductible then $1,000 Copay
Outpatient Mental Health	Deductible then 20% Coinsurance	Deductible then $50 Copay	Deductible then $50 Copay
Vision	Deductible then 20% Coinsurance	Deductible then $50 Copay	Deductible then $50 Copay
Chiropractor	Deductible then 20% Coinsurance	Deductible then $50 Copay	Deductible then $50 Copay
Prescription Coverage	**After Deductible (except preventive drugs)** Tier 1 $5 Tier 2 $25 Tier 3 $50	**Copay per 30 Day Supply** Tier 1 $5 Tier 2 $50 Tier 3 $50%	**Copay per 30 Day Supply** Tier 1 $5 Tier 2 $50 Tier 3 $50%
Out-of-Network			
Deductible	$4,000 Single / $8,000 Family	$4,000 Single / $8,000 Family	$4,000 Single / $8,000 Family
Coinsurance	40%	40%	40%
Annual Out of Pocket Max	$13,100 Single / $26,200 Family	$13,700 Single / $27,400 Family	$13,700 Single / $27,400 Family
Extra Benefits	HSA Eligible & Exercise Rewards	Exercise Rewards	Exercise Rewards
Rates	**Option 1**	**Option 2**	**Option 3**
Single	**$439.95**	**$434.73**	**$463.55**
Subscriber and Spouse	**$879.90**	**$869.47**	**$927.10**
Subscriber and Child(ren)	**$747.92**	**$739.05**	**$788.03**
Family	**$1,253.87**	**$1,238.99**	**$1,321.13**

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2017 1st Quarter Univera Comparison for Small Groups

In Network:	Univera Access Bronze 1	Univera Preferred Access Bronze (Erie County Only)	Univera Access Bronze 2 (all other counties)
Annual Deductible	**$6,550 Single/ $13,100 Family**	**$4,500 Single / $9,000 Family**	**$4,500 Single / $9,000 Family**
Coinsurance	**0%**	**50%**	**50%**
Annual Out of Pocket Max	**$6,550 Single/ $13,100 Family**	**$6,550 Single / $13,100 Family**	**$6,550 Single / $13,100 Family**
PCP Office Visit	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Specialist Visit	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Sick Child Visit	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Radiology	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Laboratory	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Hospital Inpatient	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Outpatient Surgery	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Outpatient OT/PT/ST	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Emergency Room Care	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Ambulance	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Urgent Care	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Maternity Care	Pre/Postnatal Care: Deductible then $0 Copay (cost share may apply) Delivery: Deductible then 0% Coinsurance	Pre/Postnatal Care: Deductible then $0 Copay (cost share may apply) Delivery: Deductible then 50% Coinsurance	Pre/Postnatal Care: Deductible then $0 Copay (cost share may apply) Delivery: Deductible then 50% Coinsurance
Outpatient Mental Health	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Vision	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Chiropractor	Deductible then 0% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Prescription Coverage	**After Deductible (except preventive drugs)** Tier 1 0% Coinsurance Tier 2 0% Coinsurance Tier 3 0% Coinsurance	**After Deductible (except preventive drugs)** Tier 1 0% Coinsurance Tier 2 0% Coinsurance Tier 3 0% Coinsurance	**After Deductible (except preventive drugs)** Tier 1 0% Coinsurance Tier 2 0% Coinsurance Tier 3 0% Coinsurance
Out-of-Network			
Deductible	$13,100 Single / $26,200 Family	$9,000 Single / $18,000 Family	$9,000 Single / $18,000 Family
Coinsurance	0%	50%	50%
Annual Out of Pocket Max	$13,100 Single / $26,200 Family	$13,100 Single / $26,200 Family	$13,100 Single / $26,200 Family
Extra Benefits	HSA Eligible & Exercise Rewards	HSA Eligible & Exercise Rewards	HSA Eligible & Exercise Rewards
Rates	**Option 1**	**Option 2**	**Option 3**
Single	**$309.73**	**$314.53**	**$335.38**
Subscriber and Spouse	**$619.46**	**$629.07**	**$670.75**
Subscriber and Child(ren)	**$526.54**	**$534.71**	**$570.14**
Family	**$882.74**	**$896.42**	**$955.82**

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In Network:	Univera Access Standard Platinum	Univera Access Standard Gold	Univera Access Standard Silver	Univera Access Standard Bronze	Univera Access Standard Bronze HSA
Annual 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	**Applicable where noted**	**Applicable where noted**	**Applicable where noted**	**0%**	**50%**
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**	**$6,550 Single / $13,100 Family**
PCP Office Visit	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Specialist Visit	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Sick Child Visit	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Radiology	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Laboratory	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Hospital Inpatient	$500 Copay	Deductible then $1000 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	$35 Copay	Deductible then $40 Copay	Deductible then $50 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Emergency Room Care	$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
Maternity Care	Pre/Postnatal Care: $0 Copay (Cost Share May Apply) Delivery: $500 Copay	Pre/Postnatal Care: $0 Copay (Cost Share May Apply) Delivery: $1,000 Copay	Pre/Postnatal Care: $0 Copay (Cost Share May Apply) Delivery: Deductible then $1500 Copay	Pre/Postnatal Care: $0 Copay (Cost Share May Apply) Delivery: Deductible then 50% Coinsurance	Pre/Postnatal Care: $0 Copay (Cost Share May Apply) Delivery: Deductible then 50% Coinsurance
Outpatient Mental Health	$15 Copay	Deductible then $25 Copay	Deductible then $30 Copay	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Vision	$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
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 $10 Tier 2 $35 Tier 3 $70
Out-of-Network					
Deductible **Coinsurance** **Annual Out of Pocket Max**	$500 Single / $1,000 Family 20% $2,000 Single / $4,000 Family	$600 Single / $1,200 Family 40% $4,000 Single / $8,000 Family	$2,000 Single / $4,000 Family 40% $6,750 Single / $13,500 Family	$4,000 SIngle / $8,000 Family 50% $7,150 Single / $14,300 Family	$5,500 Single / $11,000 Family 50% $6,550 Single / $13,100 Family
Extra Benefits	Exercise Rewards	Exercise Rewards	Exercise Rewards	Exercise Rewards	HSA Eligible & Exercise Rewards
Rates	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Single	**$659.25**	**$566.12**	**$470.73**	**$339.26**	**$320.11**
Subscriber and Spouse	**$1,318.51**	**$1,132.25**	**$941.47**	**$678.53**	**$640.22**
Subscriber and Child(ren)	**$1,120.73**	**$962.41**	**$800.25**	**$576.75**	**$544.18**
Family	**$1,878.87**	**$1,613.46**	**$1,341.59**	**$966.90**	**$912.31**

This comparison is intended to be a brief summary of benefits only.
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2017 Dental Plan Offerings (Small Group)

In Network:	Univera Dental
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

In Network:	Delta Dental
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		
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 1st Quarter Vision Offerings (Small Group)

MetLife

In Network:	METLIFE 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	$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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Benefits Advocate

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

This comparison is tended to be a brief summary of benefits only.
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Bene-Care Agency, LLC Benefits Advocate

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!