Bene-Care
Insurance - Payroll - HR Solutions

2023 2nd Quarter Univera Comparison for Small Groups

In Network:	Univera Access Gold 1	Univera Access Gold 2	Univera Access Gold 4
Annual Deductible	**$1,500 Single / $3,000 Family (TF)**	**$2,000 Single / $4,000 Family (EM)**	**$1,800 Single / $3,600 Family (TF)**
Coinsurance	**0%**	**Applicable where noted**	**20%**
Annual Out of Pocket Max	**$4,000 Single / $8,000 Family (TF)**	**$8,000 Single / $16,000 Family (EM)**	**$3,600 Single / $7,200 Family (TF)**
PCP Office Visit	Deductible then $10 Copay	$10 Copay	Deductible then 20% Coinsurance
Specialist Visit	Deductible then $35 Copay	$50 Copay	Deductible then 20% Coinsurance
Telemedicine	Deductible then $0 Copay	$0 Copay	Deductible then $0 Copay
Radiology	Deductible then $35 Copay	$50 Copay	Deductible then 20% Coinsurance
Laboratory	Deductible then $35 Copay	$30 Copay	Deductible then 20% Coinsurance
Hospital Inpatient	Deductible then $500 Copay	Deductible then $1200 Copay	Deductible then 20% Coinsurance
Outpatient Surgery	Deductible then $150 Copay	Deductible then $250 Copay	Deductible then 20% Coinsurance
Outpatient OT/PT/ST	Deductible then $10 Copay	$50 Copay	Deductible then 20% Coinsurance
Emergency Room Care	Deductible then $150 Copay	$600 Copay	Deductible then 20% Coinsurance
Ambulance	Deductible then $150 Copay	$600 Copay	Deductible then 20% Coinsurance
Urgent Care	Deductible then $35 Copay	$50 Copay	Deductible then 20% Coinsurance
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 $1,200 Copay	Pre/Postnatal Care: Deductible then $0 Copay (cost share may apply) Delivery: Deductible then 20% Coinsurance
Outpatient Mental Health	Deductible then $10 Copay	3 visits covered in full then $10 copay	Deductible then 20% Coinsurance
Chiropractor	Deductible then $10 Copay	$10 Copay	Deductible then 20% Coinsurance
Diabetic Supplies	Deductible then $10 Copay	$10 Copay	Deductible then 20% Coinsurance
Prescription Coverage	**After Deductible (except preventive drugs*)** Tier 1 $5 Tier 2 $45 Tier 3 50%	**Copay per 30 Day Supply** Tier 1 $10 Tier 2 40% Tier 3 50%	**After Deductible (except preventive drugs*)** Tier 1 $5 Tier 2 $45 Tier 3 50%
Out-of-Network Deductible	$5,000 Single / $10,000 Family	$5,000 Single / $10,000 Family	$5,000 Single / $10,000 Family
Coinsurance	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
Extra Benefits	HSA Eligible & Wellness Rewards	Wellness Rewards	HSA Eligible & Wellness Rewards
Rates - With Pediatric Dental	**Option 1**	**Option 2**	**Option 3**
Single	**$649.16**	**$599.32**	**$631.64**
Subscriber and Spouse	**$1,298.32**	**$1,198.64**	**$1,263.28**
Subscriber and Child(ren)	**$1,103.57**	**$1,018.84**	**$1,073.79**
Family	**$1,850.11**	**$1,708.06**	**$1,800.17**
Rates - No Pediatric Dental	**Option 1**	**Option 2**	**Option 3**
Single	**$647.54**	**$597.81**	**$630.05**
Subscriber and Spouse	**$1,295.08**	**$1,195.62**	**$1,260.10**
Subscriber and Child(ren)	**$1,100.82**	**$1,016.28**	**$1,071.09**
Family	**$1,845.49**	**$1,703.76**	**$1,795.64**

This comparison is intended to be a brief summary of benefits only.
It is not a contract. In the event of a dispute, subscriber contract will control.

Bene-Care Inc.
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In Network:	Univera Access Gold 5	Univera Clear Gold
Annual Deductible	**$2,000 Single / $4,000 Family (TF)**	**$0**
Coinsurance	**Applicable where noted**	**0%**
Annual Out of Pocket Max	**$5,500 Single / $11,000 Family (TF)**	**$6,500 Single / $13,000 Family (EM)**
PCP Office Visit	Deductible then $25 Copay	Up to $50 Copay
Specialist Visit	Deductible then $40 Copay	Up to $100 Copay
Telemedicine	Deductible then $0 Copay	$0 Copay
Radiology	Deductible then $40 Copay	Up to $100 Copay
Laboratory	Deductible then $40 Copay	Up to $50 Copay
Hospital Inpatient	Deductible then $500 Copay	Up to $4,000 Copay
Outpatient Surgery	Deductible then $150 Copay	Up to $1,000 Copay
Outpatient OT/PT/ST	Deductible then $40 Copay	Up to $50 Copay
Emergency Room Care	Deductible then $150 Copay	Up to $200 Copay
Ambulance	Deductible then $150 Copay	Up to $200 Copay
Urgent Care	Deductible then $40 Copay	Up to $100 Copay
Maternity Care	Pre/Postnatal Care: Deductible then $0 Copay (cost share may apply) Delivery: Deductible then $500 Copay	Pre/Postnatal Care: $0 Copay (Cost Share May Apply) Delivery: Up to $4,000 Copay
Outpatient Mental Health	Deductible then $25 Copay	3 visits covered in full then up to $50 copay
Chiropractor	Deductible then $25 Copay	Up to $50 Copay
Diabetic Supplies	Deductible then $25 Copay	Up to $50 Copay
Prescription Coverage	**After Deductible (except preventive drugs*)** Tier 1 $5 Tier 2 $45 Tier 3 $90	**Copay per 30 Day Supply** Tier 1 $10 Tier 2 $50 Tier 3 $100
Out-of-Network Deductible **Coinsurance** **Annual Out of Pocket Max**	$5,000 Single / $10,000 Family 40% $10,000 Single / $20,000 Family	**$0** **0%** $9,750 Single / $19,500 Family
Extra Benefits	HSA Eligbile & Wellness Rewards	Wellness Rewards
Rates - With Pediatric Dental	**Option 4**	**Option 5**
Single	**$611.60**	**$682.93**
Subscriber and Spouse	**$1,223.20**	**$1,365.86**
Subscriber and Child(ren)	**$1,039.72**	**$1,160.98**
Family	**$1,743.06**	**$1,946.35**
Rates - No Pediatric Dental	**Option 4**	**Option 5**
Single	**$610.07**	**$681.22**
Subscriber and Spouse	**$1,220.14**	**$1,362.44**
Subscriber and Child(ren)	**$1,037.12**	**$1,158.07**
Family	**$1,738.70**	**$1,941.48**

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