



Bright Choices® Benefits Exchange™ — 2012

REINVENTING YOUR BENEFITS

The Guilderland Chamber of Commerce's 2012 benefits program gives you more choice with lower costs. We have partnered with Bouchey & Clarke Benefits Inc. and Liazon to develop the Bright Choices® program, which gives you:

Choice of plans – A wide range of choices for Medical and Dental coverage, including Health Savings Accounts for qualified health plans

Communications and Decision Support – To ensure that we are creating effective consumers, Liazon's Bright Choices portal provides rich decision support tools that reveal the actual costs of benefits, help consumers build their own personalized benefits portfolios and educate them to make more informed decisions when using healthcare services.

Service and Support – Bouchey & Clarke Benefits Inc. and Liazon take care of all service so you can focus on your business, not on benefits. We handle all benefits administration – eligibility, enrollment and carrier connections – and we support your employees with a dedicated Consumer Advocacy Center that helps them solve any benefit-related issues.

Questions? Call Bouchey & Clarke Benefits, Inc. at (518) 272-9866 or Liazon at 1-866-LIAZON-1 (1-866-542-9661)

These plans are only available to businesses who choose to participate in the Bright Choices program.
Application Deadline: Applications are due 15 days in advance of the effective date of coverage.
Administrative Fees: Rates shown do not include administrative fees. A \$7 monthly administrative fee is charged per medical contract. A \$2 monthly fee is charged per dental contract.
Rates: Health insurance rates only apply to groups with 50 or fewer total eligible employees. All other insurance products and rates apply to all groups, regardless of size. Billing is done quarterly, with monthly payment options.

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



Provision	Copay Plans		Transitional/Hybrid Plans			Health Savings Account Plans		
	HMO \$25	EPO \$30/50	EPO \$30/\$250	EPO \$30/\$1,250	EPO \$50/\$1,250	EPO HD \$1,500	EPO HD \$3,500	EPO HD \$5,000
	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5	OPTION 6	OPTION 7	OPTION 8
Premium (Monthly)	Small Group \$467.83 Single \$935.66 Two-Person \$1,239.75 Family Sole Proprietor \$533.33 Single \$1,066.65 Two-Person \$1,413.30 Family	Small Group \$392.74 Single \$785.48 Two-Person \$1,040.76 Family Sole Proprietor \$447.73 Single \$895.43 Two-Person \$1,186.46 Family	Small Group \$399.28 Single \$798.57 Two-Person \$1,058.10 Family Sole Proprietor \$455.18 Single \$910.36 Two-Person \$1,206.23 Family	Small Group \$353.45 Single \$706.91 Two-Person \$936.66 Family Sole Proprietor \$402.93 Single \$805.87 Two-Person \$1,067.78 Family	Small Group \$288.13 Single \$576.27 Two-Person \$763.57 Family Sole Proprietor \$328.48 Single \$656.94 Two-Person \$870.46 Family	Small Group \$289.31 Single \$575.82 Two-Person \$762.97 Family Sole Proprietor \$329.80 Single \$656.44 Two-Person \$869.78 Family	Small Group \$202.26 Single \$390.36 Two-Person \$517.23 Family Sole Proprietor \$230.56 Single \$445.02 Two-Person \$589.64 Family	Small Group \$105.79 Single \$207.66 Two-Person \$275.15 Family Sole Proprietor \$120.60 Single \$236.74 Two-Person \$313.67 Family
Preventive Care	Approved preventive care services covered in full.							
Physician Visit	\$25	\$30	\$30	\$30	\$50	Deductible then 20%	Deductible then Covered in Full	Deductible then Covered in Full
Specialist Visit	\$25	\$50	\$30	\$30	\$50	Deductible then 20%	Deductible then Covered in Full	Deductible then Covered in Full
Hospital Stay	\$500	\$1,000	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then Covered in Full	Deductible then Covered in Full
Outpatient Surgery	\$100	\$200	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then Covered in Full	Deductible then Covered in Full
Emergency Room	\$100	\$100	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then Covered in Full	Deductible then Covered in Full
Ambulance	\$100	\$100	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then 20%	Deductible then Covered in Full	Deductible then Covered in Full
Urgent Care	\$35	\$40	\$40	\$40	\$60	Deductible then 20%	Deductible then Covered in Full	Deductible then Covered in Full
Prescriptions	\$4/50%, Mail Order copay is 2.5 times Pharmacy Copay	\$10 Tier 1 only%, Mail Order copay is 2.5 times Pharmacy Copay	\$250 Deductible, then \$10/\$50/50%	\$250 Deductible, then \$10/\$50/\$80 (Tier 1 and MO Carved out of the Deductible)	\$10 Tier 1 only%, Mail Order copay is 2.5 times Pharmacy Copay	Deductible then Copay is 50%, Mail Order copay is 2.5 times Pharmacy Copay**	Deductible then Copay is \$4/50% , Mail Order copay is 2.5 times Pharmacy Copay**	Deductible then Copay is \$10 Tier 1 only, Mail Order copay is 2.5 times Pharmacy Copay**
Dependent Rider	Up to age 26 on all plans regardless of student status; Domestic partner covered.							
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Deductible	In-Network: None Out-of-Network: N/A	In-Network: None Out-of-Network: N/A	In-Network: \$250 Single \$500 Family Out-of-Network: N/A	In-Network: \$1,250 Single \$3,125 Family Out-of-Network: N/A	In-Network: \$1,250 Single \$3,125 Family Out-of-Network: N/A	In-Network: \$1,500 Single \$3,000 Family Out-of-Network: N/A	In-Network: \$3,500 Single \$7,000 Family Out-of-Network: N/A	In-Network: \$5,000 Single \$10,000 Family Out-of-Network: N/A
Coinsurance	In-Network: None Out-of-Network: N/A	In-Network: None Out-of-Network: N/A	In-Network: 20% Out-of-Network: N/A	In-Network: 20% Out-of-Network: N/A	In-Network: 20% Out-of-Network: N/A	In-Network: 20% Out-of-Network: N/A	In-Network: None Out-of-Network: N/A	In-Network: None Out-of-Network: N/A
Out-of-Pocket Maximum	In-Network: None Out-of-Network: N/A	In-Network: None Out-of-Network: N/A	In-Network: \$2,000 Single \$4,000 Family Out-of-Network: N/A	In-Network: \$4,000 Single \$10,000 Family Out-of-Network: N/A	In-Network: \$4,000 Single \$10,000 Family Out-of-Network: N/A	In-Network: \$4,000 Single \$8,000 Family Out-of-Network: N/A	In-Network: \$4,500 Single \$8,000 Family Out-of-Network: N/A	In-Network: \$5,000 Single \$10,000 Family Out-of-Network: N/A

**Medications on the CDPHP Preventive Drug List are no longer subject to the deductible in High Deductible plans.

Account Setup and Fees	No fees for Liazon customers
Maximum Pretax Contributions	Single: \$3,100 Family: \$6,250 Catch-up: An additional \$1,000 per year (if you're age 55 or older)
Balances	Account earns interest tax-free and balances roll over for future years

DENTAL INSURANCE

Provision	Low Plan	Middle Plan	High Plan
Preventive	In-Network: 100% Out-of-Network: 80%	In-Network: 100% Out-of-Network: 90%	In-Network: 100% Out-of-Network: 100%
Basic	In-Network: 80% Out-of-Network: 50%	In-Network: 80% Out-of-Network: 70%	In-Network: 90% Out-of-Network: 80%
Major	In-Network: 0% Out-of-Network: 0%	In-Network: 50% Out-of-Network: 25%	In-Network: 60% Out-of-Network: 50%
Orthodontia	In-Network: 0% Out-of-Network: 0%	In-Network: 0% Out-of-Network: 0%	In-Network: 50% Out-of-Network: 50% (Lifetime Maximum: \$1,000/person)
Deductible	In-Network: \$0 Out-of-Network: \$50/person (\$150 family maximum; Applies to Basic and Major treatments only.)		
Calendar Year Maximum	In-Network: \$750/person Out-of-Network: \$500/person	In-Network: \$1,000/person Out-of-Network: \$750/person	In-Network: \$1,500/person Out-of-Network: \$1,000/person
Rates (Monthly)	Employee: \$19.12 Employee + Spouse: \$40.46 Employee + Child(ren): \$45.32 Family: \$67.43	Employee: \$34.48 Employee + Spouse: \$62.58 Employee + Child(ren): \$73.96 Family: \$106.54	Employee: \$50.73 Employee + Spouse: \$100.16 Employee + Child(ren): \$112.21 Family: \$163.38


VISION INSURANCE

	Frequency	Copay/Allowance
Eye Examination	1 per Year	\$10 Copay
Lenses	1 per Year	\$25 Copay; Up to \$130 Allowance
Frames	1 Every 2 Years	\$25 Copay; Up to \$130 Allowance
Contacts	1 per Year	\$25 Copay; Up to \$130 Allowance
Rates (Monthly)	\$8.94 \$17.43 \$18.33 \$25.48	Employee Employee + Spouse Employee + Child(ren) Family