



Benefit & Rates Comparison (Effective: 1-Jan-10)

(Version Updated: 2009-11-03)

SB-C-5		SimplyBlue - Copay Option	
Rating Region: Rochester		Small Group	Sole Proprietor
Rate			
4-Tier- Ind/Subscriber Spouse/Subscriber Child(ren)/Family			
Single	\$312.24		\$359.07
Sub w/Spouse	\$761.85		\$876.12
Sub w/Child	\$633.38		\$728.39
Sub w/Children	\$633.38		\$728.39
Sub w/Spouse and one or more Children	\$806.98		\$928.02
<small>We are quoting these rates on the express condition that, if the rates actually approved by the New York State Insurance Department are different than the rates quoted above, your rates for the effective date will change.</small>			

Signature: _____ Title: _____ Date: _____

Group Name: _____ Total Employees: _____ Total Eligible: _____

Group Number: _____

Coverage Effective Date: _____ Rating Tier Selected: _____
(if more than one available)

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Plan features			
Primary Care Physician (PCP)	Not required		
Referrals	Not required		
Out of network benefits	Covered at 60%, subject to the deductible		
Out of area benefits	Coverage provided worldwide through the BlueCard® program.		
Student/Dependent coverage	Qualified dependents are covered to age 19. Qualified students are covered to age 23.		
Domestic partner	Covered		
Wellness Incentives	Health Club Reimbursement - Up to \$300. Blue365 - Exclusive access to information, discounts & savings.		
Plan cost-sharing highlights			
Office visit copay (Primary Care Physician)	Adults and Children: \$30 Copay per visit		
Office visit copay (Specialist)	\$50 copay per visit		
Coinsurance	In-network: None; Out-of-network: 40%		
Deductible	In-network: None Out of Network \$2,000 individual /\$6,000 family		
Out of pocket maximum	Combined in and out-of-network: \$6,000 individual/\$18,000 family		
Lifetime maximum	None		
Plan Benefits			
Preventive Healthcare Services	In-Network	Out Of Network	
Well child visits	Covered in full	Covered in full	
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 60%, subject to the deductible for one routine exam per year	
Adult immunizations	Covered in full	Covered at 60%, subject to the deductible	
Mammography	Covered in full	Covered at 60%, subject to the deductible	
Pap smear	Covered in full	Covered at 60%, subject to the deductible	
Routine GYN Exam	Covered in full	Covered at 60%, subject to the deductible	
Prostate cancer screening	Covered in full	Covered at 60%, subject to the deductible	
Routine vision	\$50 copay for one routine exam every year; \$60 eyewear allowance available per year	Covered at 60%, subject to the deductible for one routine exam per year. \$60 eyewear allowance available per year	
Colonoscopy	Preventive and diagnostic covered in full	Covered at 60%, subject to the deductible	

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Physician Office Services	In-Network	Out Of Network
Diagnostic office visits	\$30 copay per visit to your PCP; \$50 copay per visit to a specialist	Covered at 60%, subject to the deductible
Diagnostic x-rays	\$75 copay per visit	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	\$50 copay per visit to a specialist.	Covered at 60%, subject to the deductible
Allergy tests	\$30 copay per visit to your PCP. \$50 copay per visit to a specialist.	Covered at 60%, subject to the deductible
Allergy injections	\$30 copay per visit to your PCP; \$50 copay per visit to a specialist	Covered at 60%, subject to the deductible
Chemotherapy	\$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit	Covered at 60%, subject to the deductible
Radiation therapy	\$50 copay per visit	Covered at 60%, subject to the deductible
Maternity Services	In-Network	Out Of Network
Prenatal and postpartum care	Covered in full	Covered at 60%, subject to the deductible
Hospital care for mom (including delivery)	Covered in full	Covered at 60%, subject to the deductible
Newborn nursery care	Covered in full	Covered at 60%, subject to the deductible
Prescription Drug	In-Network	Out Of Network
Short-term and maintenance drugs	\$5/\$35/\$70; \$0 copay for generics for children to age 19.	Not covered

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Inpatient Hospital Benefits	In-Network	Out Of Network
Hospital benefits	Subject to \$500 copay per day for up to 4 days per admission for unlimited days	Covered at 60%, subject to the deductible.
Physician visits in the hospital	Covered in full	Covered at 60%, subject to the deductible
Inpatient physical rehabilitation	Subject to \$500 copay per day for up to 4 days per admission and 60 days per year.	Covered at 60%, subject to the deductible for up to 60 days per year
Surgery	\$250 Copay	Covered at 60%, subject to the deductible
Anesthesia	Covered in full	Covered in full
Emergency Care	In-Network	Out Of Network
Emergency room care	\$250 copay per visit, unless admitted within 24 hours	\$250 copay per visit, unless admitted within 24 hours
Freestanding urgent care center	\$75 copay per visit	Covered at 60%, subject to the deductible
Ambulance	\$250 copay	\$250 copay
Outpatient Hospital Benefits	In-Network	Out Of Network
Diagnostic x-rays	\$75 copay per visit	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	\$50 copay per visit to a specialist	Covered at 60%, subject to the deductible
Surgical care	\$250 copay	Covered at 60%, subject to the deductible
Chemotherapy	\$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit	Covered at 60%, subject to the deductible
Radiation Therapy	\$50 copay per visit	Covered at 60%, subject to the deductible
Mental Health and Chemical Dependence	In-Network	Out Of Network
Inpatient mental health care	Subject to \$500 copay per day for up to 4 days per admission and up to 30 days per year	Covered at 60%, subject to the deductible for up to 30 days per year
Outpatient mental health care	\$50 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office.	Covered at 60%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office.
Inpatient chemical dependence	Subject to \$500 copay per day for up to 4 days per admission. Includes 7 days for detoxification and rehabilitation per year; limited to 2 admissions per lifetime.	Covered at 60%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime.
Outpatient chemical dependence	\$50 copay per visit for up to 60 visits per year	Covered at 60%, subject to the deductible for up to 60 visits per year

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Other Services	In-Network	Out Of Network
Diabetic insulin and supplies	\$30 copay for up to a 30 day supply	Covered at 60%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Subject to \$500 copay per day for up to 4 days per admission and up to 45 days per year	Covered at 60%, subject to the deductible for up to 45 days per year
Home care	Covered in full for up to 40 visits per year	Covered at 60%, subject to a \$50 deductible for up to 40 visits per year.
Hospice	Covered in full for unlimited visits	Covered at 60%, subject to the deductible for unlimited visits per year
Outpatient therapy	\$50 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 60%, subject to the deductible for a combined total of 45 visits per year for physical, speech, and occupational therapy
Durable medical equipment	Covered at 50% for up to \$15,000 per year combined with external prosthetics and orthotics	Not covered
External prosthetics	Covered at 50% for up to \$15,000 per year combined with DME and orthotics	Not covered
Chiropractic	\$50 copay per visit	Covered at 60%, subject to the deductible
Acupuncture	\$50 copay for up to 10 visits per year	Covered at 60%, subject to the deductible, for up to 10 visits per year
Dental	\$50 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	\$50 copay for one routine hearing exam per year. Hearing aids covered up to \$600 every 3 years for children to age 19.	Covered at 60%, subject to the deductible, for one routine hearing exam per year. Hearing aids covered up to \$600 every 3 years for children to age 19.

This is not a contract or binding agreement, but a summary of benefits and services. You should rely on the subscriber contract as the complete description of member rights, responsibilities, benefits available under the benefit plan, and the definition of contract year as it applies to any benefit limitations. In the event of a dispute between this summary and your member contract, the member contract will prevail.

Certain services require pre-certification. Please refer to your contract for additional information regarding applicable services and penalties charged if pre-certification is not obtained.