

## 2019 Quarter 1: Employer Group Rates Excelsus BCBS SimplyBlue+ Platinum Copay and Hybrid Plans

Highlighted benefits denote a change from 2018

\*Services subject to deductible

	Platinum 2	Platinum 3	Platinum 4	Platinum 5	Platinum 6	Standard Platinum
<b>Individual Deductible (Annual)</b>	n/a	n/a	\$250	n/a	n/a	n/a
<b>Family Deductible (Annual)</b>	n/a	n/a	\$500	n/a	n/a	n/a
<b>Individual OOP Max (Annual)</b>	\$6,350	\$4,500	\$2,000	\$6,550	\$6,550	\$2,000
<b>Family OOP Max (Annual)</b>	\$12,700	\$9,000	\$4,000	\$13,100	\$13,100	\$4,000
<b>Accumulator Type</b>	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
<b>Preventive Services</b>	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
<b>PCP Office Visit</b>	\$15 Copay	\$25 Copay	\$15 Copay	\$25 Copay	\$30 Copay	\$15 Copay
<b>Specialist Visit</b>	\$25 Copay	\$40 Copay	\$25 Copay	\$40 Copay	\$50 Copay	\$35 Copay
<b>Telemedicine Visit</b>	\$15 PCP/\$25 Specialist	\$25 PCP/\$40 Specialist	\$15 PCP/\$25 Specialist	\$25 PCP/\$40 Specialist	\$30 PCP/\$50 Specialist	\$15 PCP/\$35 Specialist
<b>Routine Eye Exam</b>	\$25 Copay	\$40 Copay	\$25 Copay	\$40 Copay	\$50 Copay	Not Covered
<b>Eyewear</b>	\$60 Allowance	\$60 Allowance	\$60 Allowance	\$60 Allowance	\$60 Allowance	Not Covered
<b>Hospital Inpatient</b>	\$250 Copay	\$500 Copay	20% Coinsurance*	\$750 Copay	\$750 Copay	\$500 Copay
<b>Outpatient Surgery</b>	\$150 Copay	\$150 Copay	20% Coinsurance*	\$250 Copay	\$250 Copay	\$100 Copay
<b>Emergency Room Care</b>	\$150 Copay	\$150 Copay	\$150 Copay	\$250 Copay	\$250 Copay	\$100 Copay
<b>Urgent Care Center</b>	\$25 Copay	\$40 Copay	\$25 Copay	\$40 Copay	\$50 Copay	\$55 Copay
<b>Diabetic Supplies (per 30 days)</b>	\$15 Copay	\$25 Copay	\$15 Copay	\$25 Copay	\$30 Copay	\$15 Copay
<b>Durable Medical Equipment</b>	50% Coinsurance	50% Coinsurance	50% Coinsurance*	50% Coinsurance	50% Coinsurance	10% Coinsurance
<b>Prescription Coverage</b>	Tier 1/\$5 Copay	Tier 1/\$5 Copay	Tier 1/\$5 Copay	Tier 1/\$5 Copay	Tier 1/\$5 Copay	Tier 1/\$10 Copay
	Tier 2/\$30 Copay	Tier 2/\$35 Copay	Tier 2/\$25 Copay	Tier 2/\$35 Copay	Tier 2/\$35 Copay	Tier 2/\$30 Copay
	Tier 3/\$50 Copay	Tier 3/\$70 Copay	Tier 3/\$50 Copay	Tier 3/\$70 Copay	Tier 3/\$70 Copay	Tier 3/\$60 Copay
<b>Enrollment Code</b>	SMT1	SMW3	SNZ1	SOF5	SOH1	SMR5
<b>Monthly Rate Tiers</b>						
<b>Single</b>	\$682.33	\$669.78	\$685.85	\$663.07	\$656.07	\$684.76
<b>Subscriber and Spouse</b>	\$1,364.66	\$1,339.56	\$1,371.70	\$1,326.14	\$1,312.14	\$1,369.52
<b>Subscriber and Child(ren)</b>	\$1,159.96	\$1,138.63	\$1,165.95	\$1,127.22	\$1,115.32	\$1,164.09
<b>Family</b>	\$1,944.64	\$1,908.87	\$1,954.67	\$1,889.75	\$1,869.80	\$1,951.57

## 2019 Quarter 1: Employer Group Rates Excelsus BCBS SimplyBlue+ Gold Copay and High Deductible Health Plans

Highlighted benefits denote a change from 2018

\*Services subject to deductible  
<sup>h</sup>HSA compatible

	Gold 1	Gold 5	Gold 6 <sup>h</sup>	Gold 20 <sup>h</sup>
<b>Individual Deductible (Annual)</b>	n/a	n/a	\$1,400	\$1,800
<b>Family Deductible (Annual)</b>	n/a	n/a	\$2,800	\$3,600
<b>Individual OOP Max (Annual)</b>	\$6,850	\$6,850	\$2,800	\$3,600
<b>Family OOP Max (Annual)</b>	\$13,700	\$13,700	\$5,600	\$7,200
<b>Accumulator Type</b>	Embedded	Embedded	Aggregate	Aggregate
<b>Preventive Services</b>	Covered in Full	Covered in Full	Covered in Full	Covered in Full
<b>PCP Office Visit</b>	\$25 Copay	\$40 Copay	15% Coinsurance*	20% Coinsurance*
<b>Specialist Visit</b>	\$40 Copay	\$60 Copay	15% Coinsurance*	20% Coinsurance*
<b>Telemedicine Visit</b>	\$25 PCP/\$40 Specialist	\$40 PCP/\$60 Specialist	15% Coinsurance*	20% Coinsurance*
<b>Routine Eye Exam</b>	\$40 Copay	\$60 Copay	15% Coinsurance*	20% Coinsurance*
<b>Eyewear</b>	\$60 Allowance	\$60 Allowance	\$60 Allowance	\$60 Allowance
<b>Hospital Inpatient</b>	\$1,000 Copay	<b>\$1,000 Copay</b>	15% Coinsurance*	20% Coinsurance*
<b>Outpatient Surgery</b>	\$450 Copay	<b>\$500 Copay</b>	15% Coinsurance*	20% Coinsurance*
<b>Emergency Room Care</b>	\$450 Copay	<b>\$500 Copay</b>	15% Coinsurance*	20% Coinsurance*
<b>Urgent Care Center</b>	\$40 Copay	\$60 Copay	15% Coinsurance*	20% Coinsurance*
<b>Diabetic Supplies (per 30 days)</b>	\$25 Copay	\$40 Copay	15% Coinsurance*	20% Coinsurance*
<b>Durable Medical Equipment</b>	50% Coinsurance	50% Coinsurance	50% Coinsurance*	50% Coinsurance*
<b>Prescription Coverage</b>	Tier 1/\$15 Copay Tier 2/40% Coinsurance Tier 3/50% Coinsurance	Tier 1/\$15 Copay Tier 2/\$50 Copay Tier 3/50% Coinsurance	Tier 1/\$5 Copay* Tier 2/\$35 Copay* Tier 3/\$70 Copay*	Tier 1/\$5 Copay* Tier 2/\$45 Copay* Tier 3/\$90 Copay*
<b>Enrollment Code</b>	SMU7	SMX9	SNB1	SOK3
<b>Monthly Rate Tiers</b>				
<b>Single</b>	<b>\$593.08</b>	<b>\$585.78</b>	<b>\$556.85</b>	<b>\$532.29</b>
<b>Subscriber and Spouse</b>	<b>\$1,186.16</b>	<b>\$1,171.56</b>	<b>\$1,113.70</b>	<b>\$1,064.58</b>
<b>Subscriber and Child(ren)</b>	<b>\$1,008.24</b>	<b>\$995.83</b>	<b>\$946.65</b>	<b>\$904.89</b>
<b>Family</b>	<b>\$1,690.28</b>	<b>\$1,669.47</b>	<b>\$1,587.02</b>	<b>\$1,517.03</b>

## 2019 Quarter 1: Employer Group Rates Excelsus BCBS SimplyBlue+ Gold Hybrid Plans

Highlighted benefits denote a change from 2018

\*Services subject to deductible  
<sup>h</sup>HSA compatible

	Gold 17	Gold 18	Gold 19	Gold 13	Gold 14	Standard Gold
<b>Individual Deductible (Annual)</b>	\$750	\$1,000	\$2,250	\$750	\$1,000	\$600
<b>Family Deductible (Annual)</b>	\$1,500	\$2,000	\$4,500	\$1,500	\$2,000	\$1,200
<b>Individual OOP Max (Annual)</b>	<b>\$7,000</b>	\$6,000	\$6,850	\$6,850	\$5,500	\$4,000
<b>Family OOP Max (Annual)</b>	<b>\$14,000</b>	\$12,000	\$13,700	\$13,700	\$11,000	\$8,000
<b>Accumulator Type</b>	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
<b>Preventive Services</b>	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
<b>PCP Office Visit</b>	\$25 Copay	\$30 Copay	\$40 Copay	\$15 Copay*	\$25 Copay*	\$25 Copay*
<b>Specialist Visit</b>	\$40 Copay	\$50 Copay	\$60 Copay	\$25 Copay*	\$40 Copay*	\$40 Copay*
<b>Telemedicine Visit</b>	\$25 PCP/\$40 Specialist	\$30 PCP/\$50 Specialist	\$40 PCP/\$60 Specialist	\$15 PCP*/\$25 Specialist*	\$25 PCP*/\$40 Specialist*	\$25 PCP*/\$40 Specialist*
<b>Routine Eye Exam</b>	\$40 Copay	\$50 Copay	\$60 Copay	\$25 Copay*	\$40 Copay*	Not Covered
<b>Eyewear</b>	\$60 Allowance	\$60 Allowance	\$60 Allowance	\$60 Allowance	\$60 Allowance	Not Covered
<b>Hospital Inpatient</b>	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	\$1,000 Copay*
<b>Outpatient Surgery</b>	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	\$100 Copay*
<b>Emergency Room Care</b>	\$250 Copay	\$250 Copay	\$350 Copay	\$200 Copay*	\$250 Copay*	\$150 Copay*
<b>Urgent Care Center</b>	\$40 Copay	\$50 Copay	\$60 Copay	\$25 Copay*	\$40 Copay*	\$60 Copay*
<b>Diabetic Supplies (per 30 days)</b>	\$25 Copay	\$30 Copay	\$40 Copay	\$15 Copay*	\$25 Copay*	\$25 Copay*
<b>Durable Medical Equipment</b>	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	20% Coinsurance*
<b>Prescription Coverage</b>	Tier 1/\$5 Copay	Tier 1/\$5 Copay	Tier 1/\$5 Copay	Tier 1/\$5 Copay	Tier 1/\$5 Copay	Tier 1/\$10 Copay
	<b>Tier 2/\$45 Copay</b>	Tier 2/\$45 Copay	Tier 2/\$45 Copay	Tier 2/\$25 Copay	Tier 2/\$35 Copay	Tier 2/\$35 Copay
	<b>Tier 3/\$90 Copay</b>	Tier 3/\$90 Copay	Tier 3/\$90 Copay	Tier 3/\$50 Copay	Tier 3/\$70 Copay	Tier 3/\$70 Copay
<b>Enrollment Code</b>	SOA7	SOC3	SOI7	SNM3	SNN9	SNK7
<b>Monthly Rate Tiers</b>						
<b>Single</b>	<b>\$590.07</b>	<b>\$585.81</b>	<b>\$555.69</b>	<b>\$582.24</b>	<b>\$576.76</b>	<b>\$590.55</b>
<b>Subscriber and Spouse</b>	<b>\$1,180.14</b>	<b>\$1,171.62</b>	<b>\$1,111.38</b>	<b>\$1,164.48</b>	<b>\$1,153.52</b>	<b>\$1,181.10</b>
<b>Subscriber and Child(ren)</b>	<b>\$1,003.12</b>	<b>\$995.88</b>	<b>\$944.67</b>	<b>\$989.81</b>	<b>\$980.49</b>	<b>\$1,003.94</b>
<b>Family</b>	<b>\$1,681.70</b>	<b>\$1,669.56</b>	<b>\$1,583.72</b>	<b>\$1,659.38</b>	<b>\$1,643.77</b>	<b>\$1,683.07</b>

## 2019 Quarter 1: Employer Group Rates Excelsus BCBS SimplyBlue+ Silver High Deductible Health Plans

Highlighted benefits denote a change from 2018

\*Services subject to deductible  
<sup>h</sup>HSA compatible

	Silver 2 <sup>h</sup>	Silver 4 <sup>h</sup>	Silver 14 <sup>h</sup>	Silver 16 <sup>h</sup>	Silver 17 <sup>h</sup>	Silver 19 <sup>h</sup> (New)
<b>Individual Deductible (Annual)</b>	\$2,000	\$2,500	\$2,800	\$3,200	\$3,600	\$2,250
<b>Family Deductible (Annual)</b>	\$4,000	\$5,000	\$5,600	\$6,400	\$7,200	\$4,500
<b>Individual OOP Max (Annual)</b>	\$6,650	\$6,550	\$6,550	\$6,550	\$6,550	\$6,550
<b>Family OOP Max (Annual)</b>	\$13,300	\$13,100	\$13,100	\$13,100	\$13,100	\$13,100
<b>Accumulator Type</b>	Aggregate	Aggregate	Aggregate	Aggregate	Aggregate	Aggregate
<b>Preventive Services</b>	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
<b>PCP Office Visit</b>	25% Coinsurance*	15% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	\$25 Copay*
<b>Specialist Visit</b>	25% Coinsurance*	15% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	\$50 Copay*
<b>Telemedicine Visit</b>	25% Coinsurance*	15% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	\$25 PCP*/\$50 Specialist*
<b>Routine Eye Exam</b>	25% Coinsurance*	15% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	\$50 Copay*
<b>Eyewear</b>	\$60 Allowance	\$60 Allowance	\$60 Allowance	\$60 Allowance	\$60 Allowance	\$60 Allowance
<b>Hospital Inpatient</b>	25% Coinsurance*	15% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	\$500 Copay*
<b>Outpatient Surgery</b>	25% Coinsurance*	15% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	\$300 Copay*
<b>Emergency Room Care</b>	25% Coinsurance*	15% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	\$300 Copay*
<b>Urgent Care Center</b>	25% Coinsurance*	15% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	\$50 Copay*
<b>Diabetic Supplies (per 30 days)</b>	25% Coinsurance*	15% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	\$25 Copay*
<b>Durable Medical Equipment</b>	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*
<b>Prescription Coverage</b>	Tier 1/\$5 Copay* Tier 2/\$45 Copay* Tier 3/\$90 Copay*	Tier 1/\$5 Copay* Tier 2/\$35 Copay* Tier 3/\$70 Copay*	Tier 1/\$5 Copay* Tier 2/\$45 Copay* Tier 3/\$90 Copay*	Tier 1/\$5 Copay* Tier 2/\$45 Copay* Tier 3/\$90 Copay*	Tier 1/\$5 Copay* Tier 2/\$35 Copay* Tier 3/\$70 Copay*	Tier 1/\$5 Copay* Tier 2/\$45 Copay* Tier 3/\$90 Copay*
<b>Enrollment Code</b>	SNC7	SNE3	SNU3	SOL9	SON5	SMM7
<b>Monthly Rate Tiers</b>						
<b>Single</b>	\$470.62	\$465.34	\$457.91	\$435.09	\$422.79	\$469.60
<b>Subscriber and Spouse</b>	\$941.24	\$930.68	\$915.82	\$870.18	\$845.58	\$939.20
<b>Subscriber and Child(ren)</b>	\$800.05	\$791.08	\$778.45	\$739.65	\$718.74	\$798.32
<b>Family</b>	\$1,341.27	\$1,326.22	\$1,305.04	\$1,240.01	\$1,204.95	\$1,338.36

## 2019 Quarter 1: Employer Group Rates Excellus BCBS SimplyBlue+ Silver Hybrid Plans

Highlighted benefits denote a change from 2018

\*Services subject to deductible  
<sup>h</sup>HSA compatible

	Silver 6	Silver 18 (New)	Standard Silver
Individual Deductible (Annual)	\$2,250	\$6,550	\$1,700
Family Deductible (Annual)	\$4,500	\$13,100	\$3,400
Individual OOP Max (Annual)	\$7,500	\$7,500	\$7,500
Family OOP Max (Annual)	\$15,000	\$15,000	\$15,000
Accumulator Type	Embedded	Embedded	Embedded
Preventive Services	Covered in Full	Covered in Full	Covered in Full
PCP Office Visit	\$40 Copay*	\$50 Copay	\$30 Copay*
Specialist Visit	\$60 Copay*	\$75 Copay	\$50 Copay*
Telemedicine Visit	\$40 PCP*/\$60 Specialist*	\$50 PCP/\$75 Specialist	\$30 PCP*/\$50 Specialist*
Routine Eye Exam	\$60 Copay*	\$75 Copay	Not Covered
Eyewear	\$60 Allowance	\$60 Allowance	Not Covered
Hospital Inpatient	20% Coinsurance*	30% Coinsurance*	\$1,500 Copay*
Outpatient Surgery	20% Coinsurance*	30% Coinsurance*	\$100 Copay*
Emergency Room Care	\$350 Copay*	\$500 Copay	\$250 Copay*
Urgent Care Center	\$60 Copay*	\$75 Copay	\$70 Copay*
Diabetic Supplies (per 30 days)	\$40 Copay*	\$50 Copay	\$30 Copay*
Durable Medical Equipment	50% Coinsurance*	50% Coinsurance*	30% Coinsurance*
Prescription Coverage	Tier 1/\$5 Copay Tier 2/\$45 Copay Tier 3/\$90 Copay	Tier 1/\$10 Copay Tier 2/\$45 Copay Tier 3/\$90 Copay	Tier 1/\$10 Copay Tier 2/\$35 Copay Tier 3/\$70 Copay
Enrollment Code	SNP5	SML1	SNJ1
<b>Monthly Rate Tiers</b>			
Single	\$490.45	\$466.80	\$508.19
Subscriber and Spouse	\$980.90	\$933.60	\$1,016.38
Subscriber and Child(ren)	\$833.77	\$793.56	\$863.92
Family	\$1,397.78	\$1,330.38	\$1,448.34

## 2019 Quarter 1: Employer Group Rates Excellus BCBS SimplyBlue+ Bronze High Deductible Health Plans

Highlighted benefits denote a change from 2018

\*Services subject to deductible

<sup>h</sup>HSA compatible

	Bronze 3 <sup>h</sup>	Bronze 4 <sup>h</sup>	Bronze 5 <sup>h</sup>	Bronze 6 <sup>h</sup>	Standard Bronze	Standard Bronze HSA <sup>h</sup>
<b>Individual Deductible (Annual)</b>	\$5,000	\$6,550	\$5,500	\$4,500	\$4,000	\$5,500
<b>Family Deductible (Annual)</b>	\$10,000	\$13,100	\$11,000	\$9,000	\$8,000	\$11,000
<b>Individual OOP Max (Annual)</b>	\$6,550	\$6,550	\$6,550	\$6,550	<b>\$7,600</b>	\$6,550
<b>Family OOP Max (Annual)</b>	\$13,100	\$13,100	\$13,100	\$13,100	<b>\$15,200</b>	\$13,100
<b>Accumulator Type</b>	Aggregate	Aggregate	Aggregate	Aggregate	Embedded	Embedded
<b>Preventive Services</b>	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
<b>PCP Office Visit</b>	50% Coinsurance*	Covered in Full*	\$30 Copay*	20% Coinsurance*	50% Coinsurance*	50% Coinsurance*
<b>Specialist Visit</b>	50% Coinsurance*	Covered in Full*	\$50 Copay*	20% Coinsurance*	50% Coinsurance*	50% Coinsurance*
<b>Telemedicine Visit</b>	50% Coinsurance*	Covered in Full*	\$30 PCP*/\$50 Specialist*	20% Coinsurance*	50% Coinsurance*	50% Coinsurance*
<b>Routine Eye Exam</b>	50% Coinsurance*	Covered in Full*	\$50 Copay*	20% Coinsurance*	Not Covered	Not Covered
<b>Eyewear</b>	\$60 Allowance	\$60 Allowance	\$60 Allowance	\$60 Allowance	Not Covered	Not Covered
<b>Hospital Inpatient</b>	50% Coinsurance*	Covered in Full*	\$500 Copay*	20% Coinsurance*	50% Coinsurance*	50% Coinsurance*
<b>Outpatient Surgery</b>	50% Coinsurance*	Covered in Full*	\$350 Copay*	20% Coinsurance*	50% Coinsurance*	50% Coinsurance*
<b>Emergency Room Care</b>	50% Coinsurance*	Covered in Full*	\$350 Copay*	20% Coinsurance*	50% Coinsurance*	50% Coinsurance*
<b>Urgent Care Center</b>	50% Coinsurance*	Covered in Full*	\$50 Copay*	20% Coinsurance*	50% Coinsurance*	50% Coinsurance*
<b>Diabetic Supplies (per 30 days)</b>	50% Coinsurance*	Covered in Full*	\$30 Copay*	20% Coinsurance*	50% Coinsurance*	50% Coinsurance*
<b>Durable Medical Equipment</b>	50% Coinsurance*	Covered in Full*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*
<b>Prescription Coverage</b>	Tier 1/\$10 Copay* Tier 2/40% Coinsurance* Tier 3/50% Coinsurance*	Covered in Full*	Tier 1/\$10 Copay* Tier 2/\$35 Copay* Tier 3/\$70 Copay*	Tier 1/\$5 Copay* Tier 2/\$45 Copay* Tier 3/\$90 Copay*	Tier 1/\$10 Copay* Tier 2/\$35 Copay* Tier 3/\$70 Copay*	Tier 1/\$10 Copay* Tier 2/\$35 Copay* Tier 3/\$70 Copay*
<b>Enrollment Code</b>	SNF9	SNH5	SNV9	SOP1	SOD9	SMZ5
<b>Monthly Rate Tiers</b>						
<b>Single</b>	<b>\$364.54</b>	<b>\$353.90</b>	<b>\$376.86</b>	<b>\$386.47</b>	<b>\$382.88</b>	<b>\$367.28</b>
<b>Subscriber and Spouse</b>	<b>\$729.08</b>	<b>\$707.80</b>	<b>\$753.72</b>	<b>\$772.94</b>	<b>\$765.76</b>	<b>\$734.56</b>
<b>Subscriber and Child(ren)</b>	<b>\$619.72</b>	<b>\$601.63</b>	<b>\$640.66</b>	<b>\$657.00</b>	<b>\$650.90</b>	<b>\$624.38</b>
<b>Family</b>	<b>\$1,038.94</b>	<b>\$1,008.62</b>	<b>\$1,074.05</b>	<b>\$1,101.44</b>	<b>\$1,091.21</b>	<b>\$1,046.75</b>