



**Benefit & Rates Comparison** (Effective: 1-Jan-10) (Version Updated: 2009-11-03)

<b>SB-CD-7E</b>		<b>SimplyBlue - Copay and Deductible Option</b>	
<b>Rating Region: Utica South</b>		Small Group	Sole Proprietor
<b>Rate</b>			
2-Tier- Ind/Family			
Single	\$237.45		N/A
Sub w/Spouse	\$604.82		N/A
Sub w/Child	\$604.82		N/A
Sub w/Children	\$604.82		N/A
Sub w/Spouse and one or more Children	\$604.82		N/A
3-Tier- Ind/Subscriber 1/Family			
Single	\$237.45		N/A
Sub w/Spouse	\$458.28		N/A
Sub w/Child	\$458.28		N/A
Sub w/Children	\$626.69		N/A
Sub w/Spouse and one or more Children	\$626.69		N/A
4-Tier- Ind/Subscriber Spouse/Subscriber Child(ren)/Family			
Single	\$237.45	\$261.19	
Sub w/Spouse	\$474.90	\$522.39	
Sub w/Child	\$473.65	\$521.01	
Sub w/Children	\$473.65	\$521.01	
Sub w/Spouse and one or more Children	\$653.40	\$718.75	
<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)

[Get Eligibility Policy and Underwriting Documentation](#)

SB-CD-7E		SimplyBlue - Copay and Deductible Option	
<b>Plan features</b>			
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.		
<b>Plan cost-sharing highlights</b>			
Office visit copay (Primary Care Physician)	Adults and Children: \$40 Copay per visit		
Office visit copay (Specialist)	\$60 copay per visit		
Coinsurance	In-network: 40%; Out-of-network: 40%		
Deductible	Combined in- and out-of-network: \$3,000 individual/\$9,000 family		
Out of pocket maximum	Combined in and out-of-network: \$9,000 individual/\$27,000 family		
Lifetime maximum	None		
<b>Plan Benefits</b>			
<b>Preventive Healthcare Services</b>	<b>In-Network</b>	<b>Out Of Network</b>	
<b>Well child visits</b>	Covered in full	Covered in full	
<b>Adult routine physical exams</b>	Covered in full for 1 exam per year	Covered at 60%, subject to the deductible for one routine exam per year	
<b>Adult immunizations</b>	Covered in full	Covered at 60%, subject to the deductible	
<b>Mammography</b>	Covered in full	Covered at 60%, subject to the deductible	
<b>Pap smear</b>	Covered in full	Covered at 60%, subject to the deductible	
<b>Routine GYN Exam</b>	Covered in full	Covered at 60%, subject to the deductible	
<b>Prostate cancer screening</b>	Covered in full	Covered at 60%, subject to the deductible	
<b>Routine vision</b>	\$60 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	
<b>Colonoscopy</b>	Preventive and diagnostic covered in full	Covered at 60%, subject to the deductible	

SB-CD-7E		SimplyBlue - Copay and Deductible Option
Plan Benefits		
Physician Office Services	In-Network	Out Of Network
<b>Diagnostic office visits</b>	\$40 copay per visit to your PCP; \$60 copay per visit to a specialist	Covered at 60%, subject to the deductible
<b>Diagnostic x-rays</b>	\$100 copay per visit	Covered at 60%, subject to the deductible
<b>Diagnostic laboratory and pathology</b>	\$60 copay per visit to a specialist.	Covered at 60%, subject to the deductible
<b>Allergy tests</b>	\$40 copay per visit to your PCP. \$60 copay per visit to a specialist.	Covered at 60%, subject to the deductible
<b>Allergy injections</b>	\$40 copay per visit to your PCP; \$60 copay per visit to a specialist	Covered at 60%, subject to the deductible
<b>Chemotherapy</b>	\$40 copay for IV/injectable chemotherapy, in addition to a \$40 copay for the office visit	Covered at 60%, subject to the deductible
<b>Radiation therapy</b>	\$60 copay per visit	Covered at 60%, subject to the deductible
Maternity Services	In-Network	Out Of Network
<b>Prenatal and postpartum care</b>	Covered in full	Covered at 60%, subject to the deductible
<b>Hospital care for mom (including delivery)</b>	Subject to \$500 copay per day for up to 4 days per admission. Subject to deductible for unlimited days.	Covered at 60%, subject to the deductible
<b>Newborn nursery care</b>	Covered in full	Covered at 60%, subject to the deductible
Prescription Drug	In-Network	Out Of Network
<b>Short-term and maintenance drugs</b>	\$7 copay for generics only, \$0 copay for generics for children to age 19	Not covered

SB-CD-7E		SimplyBlue - Copay and Deductible Option	
Plan Benefits			
<b>Inpatient Hospital Benefits</b>		<b>In-Network</b>	<b>Out Of Network</b>
<b>Hospital benefits</b>		Subject to \$500 copay per day for up to 4 days per admission for unlimited days, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Physician visits in the hospital</b>		Covered at 60%, subject to the deductible	Covered at 60%, subject to the deductible
<b>Inpatient physical rehabilitation</b>		Subject to \$500 copay per day for up to 4 days per admission and 60 days per year, subject to the deductible.	Covered at 60%, subject to the deductible for up to 60 days per year
<b>Surgery</b>		Covered at 60%, subject to the deductible	Covered at 60%, subject to the deductible
<b>Anesthesia</b>		Covered at 60%, subject to the deductible	Covered at 60%, subject to the deductible
<b>Emergency Care</b>		<b>In-Network</b>	<b>Out Of Network</b>
<b>Emergency room care</b>		\$350 copay per visit, unless admitted within 24 hours	\$350 copay per visit, unless admitted within 24 hours
<b>Freestanding urgent care center</b>		\$75 copay per visit	Covered at 60%, subject to the deductible
<b>Ambulance</b>		\$350 copay	\$350 copay
<b>Outpatient Hospital Benefits</b>		<b>In-Network</b>	<b>Out Of Network</b>
<b>Diagnostic x-rays</b>		\$100 copay per visit	Covered at 60%, subject to the deductible
<b>Diagnostic laboratory and pathology</b>		\$60 copay per visit to a specialist.	Covered at 60%, subject to the deductible
<b>Surgical care</b>		Covered at 60% subject to the deductible	Covered at 60%, subject to the deductible
<b>Chemotherapy</b>		\$40 copay for IV/injectable chemotherapy, in addition to a \$40 copay for the office visit	Covered at 60%, subject to the deductible
<b>Radiation Therapy</b>		\$60 copay per visit	Covered at 60%, subject to the deductible
<b>Mental Health and Chemical Dependence</b>		<b>In-Network</b>	<b>Out Of Network</b>
<b>Inpatient mental health care</b>		Subject to \$500 copay per day for up to 4 days per admission and up to 30 days per year, subject to the deductible	Covered at 60%, subject to the deductible for up to 30 days per year
<b>Outpatient mental health care</b>		\$60 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider 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.
<b>Inpatient chemical dependence</b>		Subject to \$500 copay per day for up to 4 days per admission, subject to the deductible. 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.
<b>Outpatient chemical dependence</b>		\$60 copay per visit for up to 60 visits per year	Covered at 60%, subject to the deductible for up to 60 visits per year

SB-CD-7E		SimplyBlue - Copay and Deductible Option
Plan Benefits		
Other Services	In-Network	Out Of Network
<b>Diabetic insulin and supplies</b>	\$40 copay for up to a 30 day supply	Covered at 60%, subject to the deductible for up to a 30 day supply
<b>Skilled nursing facility</b>	Subject to \$500 copay per day for up to 4 days per admission and up to 45 days per year, subject to the deductible	Covered at 60%, subject to the deductible for up to 45 days per year
<b>Home care</b>	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.
<b>Hospice</b>	Covered in full for unlimited days	Covered at 60%, subject to the deductible for unlimited visits per year
<b>Outpatient therapy</b>	\$60 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
<b>Durable medical equipment</b>	Covered at 50% for up to \$15,000 per year combined with external prosthetics and orthotics	Not covered
<b>External prosthetics</b>	Covered at 50% for up to \$15,000 per year combined with DME and orthotics	Not covered
<b>Chiropractic</b>	\$60 copay per visit	Covered at 60%, subject to the deductible
<b>Acupuncture</b>	\$60 copay for up to 10 visits per year	Covered at 60%, subject to the deductible, for up to 10 visits per year
<b>Dental</b>	\$60 copay per visit 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
<b>Hearing</b>	\$60 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.