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Rating Region: Syracuse  
Quote Effective: 04/01/2015 - 06/30/2015  
Version Updated: 01/26/2015

| Plan ID   | 78124NY0980105-00   |   | 78124NY0980025-00   |   | 78124NY0990025-00  |   |
|---|---|---|---|---|--|---|
| Enrollment Code                                       | SEEA  |   | SAAY  |   | SNNG   |   |
| Plan Name   | SimplyBlue Plus Gold 3  |   | SimplyBlue Plus Platinum 2  |   | SimplyBlue Plus Silver 5   |   |
| Plan Highlights                                       | Predictable out-of-pocket costs without a deductible, includes ExerciseRewards.                           |   | Predictable out-of-pocket costs without a deductible, includes ExerciseRewards.                           |   | A deductible is applied to all covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full. Plan includes ExerciseRewards. |   |
| Plan Type   | Copay   |   | Copay   |   | Hybrid   |   |
| HSA Eligible  | No  |   | No  |   | No   |   |
| Quote Effective                                       | 04/01/2015 - 06/30/2015   |   | 04/01/2015 - 06/30/2015   |   | 04/01/2015 - 06/30/2015  |   |
| Rate (\$)   | Small Group   |   | Small Group   |   | Small Group  |   |
| <b>Subscriber Spouse/Subscriber Child(ren)/Family</b> |   |   |   |   |  |   |
| Single  | \$536.62  |   | \$609.18  |   | \$457.88   |   |
| Subscriber & Spouse                                   | \$1,073.24  |   | \$1,218.36  |   | \$915.76   |   |
| Subscriber & Child(ren)                               | \$912.25  |   | \$1,035.61  |   | \$778.40   |   |
| Family  | \$1,529.37  |   | \$1,736.16  |   | \$1,304.96   |   |
| Plan features   |   |   |   |   |  |   |
| Primary Care Physician (PCP)                          | Not Required  |   | Not Required  |   | Not Required   |   |
| Referrals   | Not Required  |   | Not Required  |   | Not Required   |   |
| Out of network benefits                               | Covered at 80%, subject to the deductible   |   | Covered at 80%, subject to the deductible   |   | Covered at 60%, subject to the deductible  |   |
| Out of area benefits                                  | Coverage provided worldwide through our BlueCard® Network   |   | Coverage provided worldwide through our BlueCard® Network   |   | Coverage provided worldwide through our BlueCard® Network  |   |
| Student/Dependent coverage                            | Qualified dependents are covered to age 26  |   | Qualified dependents are covered to age 26  |   | Qualified dependents are covered to age 26   |   |
| Domestic partner                                      | Covered   |   | Covered   |   | Covered  |   |
| Wellness Incentives                                   | ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues and/or fitness classes |   | ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues and/or fitness classes |   | ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues and/or fitness classes  |   |
| Plan cost-sharing highlights                          | In-Network  | Out-of-Network                            | In-Network  | Out-of-Network                            | In-Network   | Out-of-Network                            |
| Primary Care Office Visit                             | \$30 copay per visit  | Covered at 80%, subject to the deductible | \$15 copay per visit  | Covered at 80%, subject to the deductible | \$30 copay per visit, subject to deductible  | Covered at 60%, subject to the deductible |
| Specialist Office Visit                               | \$50 copay per visit  | Covered at 80%, subject to the deductible | \$25 copay per visit  | Covered at 80%, subject to the deductible | \$50 copay per visit, subject to deductible  | Covered at 60%, subject to the deductible |

|  |  |  |  |  |  |   |
|--|--|--|--|--|--|---|
| Coinsurance                                | None   | Covered at 80%   | None   | Covered at 80%   | Covered at 80%   | Covered at 60%  |
| Deductible                                 | None   | Out-of-Network: \$500 Individual / \$1,000 Family        | None   | Out-of-Network: \$500 Individual / \$1,000 Family        | In-Network: \$1,500 Individual / \$3,000 Family                        | Out-of-Network: \$1,500 Individual / \$3,000 Family     |
| Out of pocket maximum                      | In-Network: \$6,350 Individual / \$12,700 Family | Out-of-Network: \$6,350 Individual / \$12,700 Family     | In-Network: \$6,350 Individual / \$12,700 Family | Out-of-Network: \$6,350 Individual / \$12,700 Family     | In-Network: \$6,350 Individual / \$12,700 Family                       | Out-of-Network: \$6,350 Individual / \$12,700 Family    |
| Lifetime maximum                           | None   | None   | None   | None   | None   | None  |
| <b>Preventive Healthcare Services</b>      | <b>In-Network</b>                                | <b>Out-of-Network</b>                                    | <b>In-Network</b>                                | <b>Out-of-Network</b>                                    | <b>In-Network</b>  | <b>Out-of-Network</b>                                   |
| Well child visits                          | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full  | Covered at 60%, subject to the deductible               |
| Adult routine physical exams               | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full  | Covered at 60%, subject to the deductible               |
| +Adult immunizations                       | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full  | Covered at 60%, subject to the deductible               |
| +Mammography                               | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full  | Covered at 60%, subject to the deductible               |
| +Pap smear                                 | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full  | Covered at 60%, subject to the deductible               |
| Routine GYN Exam                           | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full  | Covered at 60%, subject to the deductible               |
| +Prostate cancer screening                 | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full                                  | Covered at 80%, subject to the deductible                | Covered In Full  | Covered at 60%, subject to the deductible               |
| +Colonoscopy                               | Preventive screenings covered in full            | Covered at 80%, subject to the deductible                | Preventive screenings covered in full            | Covered at 80%, subject to the deductible                | Preventive screenings covered in full                                  | Covered at 60%, subject to the deductible               |
| +Family Planning Services                  | Covered in full                                  | Covered at 80%, subject to the deductible                | Covered in full                                  | Covered at 80%, subject to the deductible                | Covered in full  | Covered at 60%, subject to the deductible               |
| <b>Physician Office Services</b>           | <b>In-Network</b>                                | <b>Out-of-Network</b>                                    | <b>In-Network</b>                                | <b>Out-of-Network</b>                                    | <b>In-Network</b>  | <b>Out-of-Network</b>                                   |
| Diagnostic office visits                   | \$30 PCP copay; \$50 Specialist copay per visit  | Covered at 80%, subject to the deductible                | \$15 PCP copay; \$25 Specialist copay per visit  | Covered at 80%, subject to the deductible                | \$30 PCP copay; \$50 Specialist copay per visit, subject to deductible | Covered at 60%, subject to the deductible               |
| Diagnostic x-rays                          | \$50 copay per visit                             | Covered at 80%, subject to the deductible                | \$25 copay per visit                             | Covered at 80%, subject to the deductible                | \$50 copay per visit, subject to the deductible                        | Covered at 60%, subject to the deductible               |
| Diagnostic laboratory and pathology        | \$30 copay per visit                             | Covered at 80%, subject to the deductible                | \$15 copay per visit                             | Covered at 80%, subject to the deductible                | \$30 copay per visit, subject to the deductible                        | Covered at 60%, subject to the deductible               |
| Allergy tests                              | \$30 PCP copay; \$50 Specialist copay per visit  | Covered at 80%, subject to the deductible                | \$15 PCP copay; \$25 Specialist copay per visit  | Covered at 80%, subject to the deductible                | \$30 PCP copay; \$50 Specialist copay per visit, subject to deductible | Covered at 60%, subject to the deductible               |
| Allergy injections                         | \$30 PCP copay; \$50 Specialist copay per visit  | Covered at 80%, subject to the deductible                | \$15 PCP copay; \$25 Specialist copay per visit  | Covered at 80%, subject to the deductible                | \$30 PCP copay; \$50 Specialist copay per visit, subject to deductible | Covered at 60%, subject to the deductible               |
| Chemotherapy                               | \$30 copay per visit                             | Covered at 80%, subject to the deductible                | \$15 copay per visit                             | Covered at 80%, subject to the deductible                | \$30 PCP copay per visit, subject to deductible                        | Covered at 60%, subject to the deductible               |
| Radiation therapy                          | \$50 copay per visit                             | Covered at 80%, subject to the deductible                | \$25 copay per visit                             | Covered at 80%, subject to the deductible                | \$50 copay per visit, subject to the deductible                        | Covered at 60%, subject to the deductible               |
| <b>Maternity Services</b>                  | <b>In-Network</b>                                | <b>Out-of-Network</b>                                    | <b>In-Network</b>                                | <b>Out-of-Network</b>                                    | <b>In-Network</b>  | <b>Out-of-Network</b>                                   |
| Prenatal care                              | Covered In Full                                  | Covered at 80%, subject to the deductible per admission  | Covered In Full                                  | Covered at 80%, subject to the deductible per admission  | Covered In Full  | Covered at 60%, subject to the deductible               |
| Hospital care for mom (including delivery) | Subject to \$500 copay per admission             | Covered at 80%, per admission, subject to the deductible | Subject to \$150 copay per admission             | Covered at 80%, per admission, subject to the deductible | Covered at 80%, subject to the deductible                              | Covered at 60% per admission, subject to the deductible |

|                                     |   |   |   |   |  |  |
|-------------------------------------|---|---|---|---|--|--|
| Newborn nursery care                | Covered In Full   | Covered at 80%, per admission, subject to the deductible  | Covered In Full   | Covered at 80%, per admission, subject to the deductible  | Covered In Full, subject to deductible   | Covered at 60% per admission, subject to the deductible  |
| Prescription Drug                   | In-Network  | Out-of-Network  | In-Network  | Out-of-Network  | In-Network   | Out-of-Network   |
| Prescription Drug Coverage          | \$15/\$50/50%   | Not Covered   | \$5/\$25/\$50   | Not Covered   | \$10/\$35/\$70   | Not Covered  |
| Inpatient Hospital Benefits         | In-Network  | Out-of-Network  | In-Network  | Out-of-Network  | In-Network   | Out-of-Network   |
| Hospital benefits                   | Subject to \$500 copay per admission for unlimited days                           | Covered at 80%, per admission for unlimited days, subject to the deductible                           | Subject to \$150 copay per admission for unlimited days                           | Covered at 80%, per admission for unlimited days, subject to the deductible                           | Covered at 80% per admission for unlimited days, subject to the deductible           | Covered at 60%, per admission for unlimited days, subject to the deductible                          |
| Physician visits in the hospital    | Covered In Full   | Covered at 80%, subject to the deductible per admission   | Covered In Full   | Covered at 80%, subject to the deductible per admission   | Covered at 80%, subject to the deductible  | Covered at 60%, subject to the deductible  |
| Inpatient physical rehabilitation   | Subject to \$500 copay per admission for up to 60 days per condition per lifetime | Covered at 80%, per admission for up to 60 days per condition per lifetime, subject to the deductible | Subject to \$150 copay per admission for up to 60 days per condition per lifetime | Covered at 80%, per admission for up to 60 days per condition per lifetime, subject to the deductible | Covered at 80% per 60 day stay per admission per lifetime, subject to the deductible | Covered at 60% per admission for up to 60 days per condition per lifetime, subject to the deductible |
| Surgery                             | Covered In Full   | Covered at 80%, subject to the deductible per admission   | Covered In Full   | Covered at 80%, subject to the deductible per admission   | Covered at 80%, subject to the deductible  | Covered at 60%, subject to the deductible  |
| Anesthesia                          | Covered In Full   | Covered at 80%, subject to the deductible per admission   | Covered In Full   | Covered at 80%, subject to the deductible per admission   | Covered at 80%, subject to the deductible  | Covered at 60%, subject to the deductible  |
| Emergency Care                      | In-Network  | Out-of-Network  | In-Network  | Out-of-Network  | In-Network   | Out-of-Network   |
| Emergency room care                 | \$250 copay per visit   | \$250 copay per visit   | \$75 copay per visit  | \$75 copay per visit  | \$350 copay per visit, subject to deductible   | \$350 copay per visit, subject to deductible   |
| Freestanding urgent care center     | \$50 copay per visit  | Covered at 80%, subject to the deductible   | \$25 copay per visit  | Covered at 80%, subject to the deductible   | \$50 copay per visit, subject to deductible  | Covered at 60%, subject to the deductible  |
| Ambulance                           | \$250 copay   | \$250 copay   | \$75 copay  | \$75 copay  | \$350 copay per visit, subject to deductible   | \$350 copay per visit, subject to deductible   |
| Outpatient Hospital Benefits        | In-Network  | Out-of-Network  | In-Network  | Out-of-Network  | In-Network   | Out-of-Network   |
| Diagnostic x-rays                   | \$50 copay per visit  | Covered at 80%, subject to the deductible   | \$25 copay per visit  | Covered at 80%, subject to the deductible   | \$50 copay per visit, subject to the deductible                                      | Covered at 60%, subject to the deductible  |
| Diagnostic laboratory and pathology | \$30 copay per visit  | Covered at 80%, subject to the deductible   | \$15 copay per visit  | Covered at 80%, subject to the deductible   | \$30 copay per visit, subject to the deductible                                      | Covered at 60%, subject to the deductible  |
| Surgical Care Facility Fee          | \$250 copay per visit   | Covered at 80%, subject to the deductible   | \$75 copay per visit  | Covered at 80%, subject to the deductible   | Covered at 80%, subject to the deductible  | Covered at 60%, subject to the deductible  |
| Chemotherapy                        | \$30 copay per visit  | Covered at 80%, subject to the deductible   | \$15 copay per visit  | Covered at 80%, subject to the deductible   | \$30 copay per visit, subject to the deductible                                      | Covered at 60%, subject to the deductible  |
| Radiation Therapy                   | \$50 copay per visit  | Covered at 80%, subject to the deductible   | \$25 copay per visit  | Covered at 80%, subject to the deductible   | \$50 copay per visit, subject to the deductible                                      | Covered at 60%, subject to the deductible  |
| Mental Health and Substance Use     | In-Network  | Out-of-Network  | In-Network  | Out-of-Network  | In-Network   | Out-of-Network   |
| Inpatient mental health care        | Subject to \$500 copay per admission for unlimited days                           | Covered at 80%, per admission for unlimited days, subject to the deductible                           | Subject to \$150 copay per admission for unlimited days                           | Covered at 80%, per admission for unlimited days, subject to the deductible                           | Covered at 80% per admission for unlimited days, subject to the deductible           | Covered at 60%, per admission for unlimited days, subject to the deductible                          |
| Outpatient mental health care       | \$50 copay per visit  | Covered at 80%, subject to the deductible   | \$25 copay per visit  | Covered at 80%, subject to the deductible   | \$50 copay per visit, subject to the deductible                                      | Covered at 60%, subject to the deductible  |
| Inpatient substance use             | Subject to \$500 copay per admission for unlimited days                           | Covered at 80%, per admission for unlimited days, subject to the deductible                           | Subject to \$150 copay per admission for unlimited days                           | Covered at 80%, per admission for unlimited days, subject to the deductible                           | Covered at 80% per admission for unlimited days, subject to the deductible           | Covered at 60%, per admission for unlimited days, subject to the deductible                          |
| Outpatient substance use            | \$50 copay per visit  | Covered at 80%, subject to the deductible   | \$25 copay per visit  | Covered at 80%, subject to the deductible   | \$50 copay per visit, subject to the deductible                                      | Covered at 60%, subject to the deductible  |

| Other Services                              | In-Network  | Out-of-Network  | In-Network   | Out-of-Network  | In-Network  | Out-of-Network  |
|---|---|---|--|---|---|---|
| Diabetic insulin and supplies               | \$30 copay per 30 day supply  | Covered at 80%, subject to the deductible   | \$15 copay per 30 day supply   | Covered at 80%, subject to the deductible   | \$30 copay, subject to deductible per 30 day supply   | Covered at 60%, subject to the deductible   |
| Skilled nursing facility                    | Subject to \$500 copay per admission for up to 200 days per year  | Covered at 80%, per admission for up to 200 days per year, subject to the deductible  | Subject to \$150 copay per admission for up to 200 days per year   | Covered at 80%, per admission for up to 200 days per year, subject to the deductible  | Covered at 80% per admission for up to 200 days per year, subject to the deductible   | Covered at 60% per admission for up to 200 days per year, subject to the deductible   |
| Home care                                   | \$30 copay per visit for 40 visits per year   | Covered at 80%, for up to 40 visits per year, subject to the deductible   | \$15 copay per visit for 40 visits per year  | Covered at 80%, for up to 40 visits per year, subject to the deductible   | \$30 copay per visit for 40 visits per year, subject to the deductible  | Covered at 60% for up to 40 visits per year, subject to the deductible  |
| Hospice                                     | Subject to \$500 copay per admission for up to 210 days per year  | Covered at 80%, for up to 210 days per year, subject to the deductible  | Subject to \$150 copay per admission for up to 210 days per year   | Covered at 80%, for up to 210 days per year, subject to the deductible  | Covered at 80% for up to 210 visits per year, subject to the deductible   | Covered at 60% for up to 210 visits per year, subject to the deductible   |
| Outpatient therapy                          | \$50 per visit for physical, speech and occupational therapy for up to 60 visits per condition per lifetime           | Covered at 80%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per condition per lifetime    | \$25 per visit for physical, speech and occupational therapy for up to 60 visits per condition per lifetime          | Covered at 80%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per condition per lifetime    | \$50 per visit, subject to deductible for physical, speech and occupational therapy for up to 60 visits per condition per lifetime        | Covered at 60%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per condition per lifetime    |
| Durable medical equipment                   | Covered at 50%  | Covered at 50%, subject to the deductible   | Covered at 50%   | Covered at 50%, subject to the deductible   | Covered at 50%, subject to the deductible   | Covered at 50%, subject to the deductible   |
| External prosthetics                        | Covered at 50%  | Covered at 50%, subject to the deductible   | Covered at 50%   | Covered at 50%, subject to the deductible   | Covered at 50%, subject to the deductible   | Covered at 50%, subject to the deductible   |
| Chiropractic                                | \$50 copay per visit  | Covered at 80%, subject to the deductible   | \$25 copay per visit   | Covered at 80%, subject to the deductible   | \$50 copay per visit, subject to the deductible   | Covered at 60%, subject to the deductible   |
| Acupuncture                                 | Not Covered   | Not Covered   | Not Covered  | Not Covered   | Not Covered   | Not Covered   |
| Hearing Aids                                | Covered at 50% for a single purchase once every 3 years   | Covered at 50%, subject to the deductible for a single purchase once every 3 years  | Covered at 50% for a single purchase once every 3 years  | Covered at 50%, subject to the deductible for a single purchase once every 3 years  | Covered at 50% , subject to the deductible for a single purchase once every 3 years   | Covered at 50%, subject to the deductible for a single purchase once every 3 years  |
| Vision Benefits                             | In-Network  | Out-of-Network  | In-Network   | Out-of-Network  | In-Network  | Out-of-Network  |
| Adult Routine Vision Exam                   | \$50 copay per visit for one routine exam every year  | Covered at 80% for one routine exam every year, subject to the deductible   | \$25 copay per visit for one routine exam every year   | Covered at 80% for one routine exam every year, subject to the deductible   | \$50 copay per visit for one routine exam every year, subject to deductible   | Covered at 60% for one routine exam every year, subject to the deductible   |
| Adult Diagnostic Vision                     | \$50 copay per visit  | Covered at 80%, subject to the deductible   | \$25 copay per visit   | Covered at 80%, subject to the deductible   | \$50 copay per visit, subject to the deductible   | Covered at 60%, subject to the deductible   |
| Adult Eyewear                               | Eyewear Reimbursement of \$60 per year  | Eyewear Reimbursement of \$60 per year  | Eyewear Reimbursement of \$60 per year   | Eyewear Reimbursement of \$60 per year  | Eyewear Reimbursement of \$60 per year  | Eyewear Reimbursement of \$60 per year  |
| Pediatric Routine Vision Exam               | \$50 copay per visit for one routine exam every year  | Covered at 80% for one routine exam every year, subject to the deductible   | \$25 copay per visit for one routine exam every year   | Covered at 80% for one routine exam every year, subject to the deductible   | \$50 copay per visit for one routine exam every year, subject to deductible   | Covered at 60% for one routine exam every year, subject to the deductible   |
| Pediatric Eyewear                           | Covered at 50% for one purchase per year  | Covered at 50%, subject to the deductible for one purchase per year   | Covered at 50% for one purchase per year   | Covered at 50%, subject to the deductible for one purchase per year   | Covered at 50%, subject to the deductible for one purchase per year   | Covered at 50%, subject to the deductible for one purchase per year   |
| Dental Benefits                             | In-Network  | Out-of-Network  | In-Network   | Out-of-Network  | In-Network  | Out-of-Network  |
| Adult Dental Care                           | Not Covered   | Not Covered   | Not Covered  | Not Covered   | Not Covered   | Not Covered   |
| Pediatric Dental: Preventative & Routine    | Covered at 80%  | Covered at 80%, subject to the deductible and balance billing   | Covered at 80%   | Covered at 80%, subject to the deductible and balance billing   | Covered at 80%, subject to the deductible   | Covered at 80%, subject to the deductible and balance billing   |
| Pediatric Major Dental Care & Medical Ortho | Covered at 50%  | Covered at 50%, subject to the deductible and balance billing   | Covered at 50%   | Covered at 50%, subject to the deductible and balance billing   | Covered at 50%, subject to the deductible   | Covered at 50%, subject to the deductible and balance billing   |
| Accidental Dental - Outpatient Surgical     | \$250 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly | Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible | \$75 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly | Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible | Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible | Covered at 60% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible |

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This is not a contract nor a Summary of Benefits and Coverage (SBC). This benefit summary is intended to highlight the coverage of this program. Benefits are determined by the terms of the Member Certificate. All benefits are subject to medical necessity.

+When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA appropriate cost share for the service will be applied. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

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