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

Plan ID	78124NY1020105-00		78124NY1020025-00		78124NY1030025-00	
Enrollment Code	**SAA5**		**SXXC**		**SAY5**	
Plan Name	**valUcare Plus Gold 3**		**valUcare Plus Platinum 2**		**valUcare 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**	
Subscriber Spouse/Subscriber Child(ren)/Family						
Single	$554.71		$629.70		$473.31	
Subscriber & Spouse	$1,109.42		$1,259.40		$946.62	
Subscriber & Child(ren)	$943.01		$1,070.49		$804.63	
Family	$1,580.92		$1,794.65		$1,348.93	
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 Nationwide through our Multiplan Network		Coverage provided Nationwide through our Multiplan Network		Coverage provided Nationwide through our Multiplan 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
Preventive Healthcare Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
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
Physician Office Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
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
Maternity Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
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 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 ano	Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject	$75 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or ano	Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject	Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject	Covered at 60% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject

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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