Excellus

Premium Rate Schedule & Contract Summary

Quote Effective: 01/01/2014 - 03/31/2014

Version Updated: 09/25/2013

Plan ID: 78124NY0980138-00	**Plan Name: SimplyBlue Plus Gold 5**	**Enrollment Code: SFFH**
Rating Region: Utica	**Small Group**	
Rate		
For the Benefits described in the Agreement, including the Certificate (identified below), the Plan will charge and Group will pay the following premium rates:		
Subscriber Spouse/Subscriber Child(ren)/Family		
Single	$497.43	
Subscriber & Spouse	$994.88	
Subscriber & Child(ren)	$845.64	
Family	$1,417.70	
Dependent Coverage To Age **26**, Pediatric Dental Coverage **No**, Domestic Partner Coverage **Yes**, Family Planning Coverage **Yes**		
Rates quoted herein are subject to change due to our implementation of the provisions of the Federal Patient Protection and Affordable Care Act.		
The Sales Representative providing this quote is a New York State licensed insurance producer employed by Excellus Health Plan. The individual represents Excellus Health Plan in this transaction and will be compensated by Excellus Health Plan in part based on this sale. The amount of compensation is based on a number of factors, including the contract selected and the volume of sales. You may request information about the expected compensation from your Sales Representative.		
***The NYS Department of Financial Services has approved our rate filing for quarterly community rates. All Rates will be considered to be on a 12 month period from the effective date of coverage unless otherwise instructed by Excellus Health Plan. The above rates are effective for the Initial Term of the Agreement. Rates for any Renewal Term will be provided to Group in a rate renewal notice.**		
A). Do you have dental coverage that includes mandated essential health pediatric dental benefits? **Yes** ☐ **No** ☐ B.) If you answered Yes, please provide the name of the company issuing the dental coverage. _____ If you answered No please be aware the ACA requires pediatric dental coverage.		

Signature: _____ **Title:** _____ **Date:** _____

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

Coverage Effective Date: _____ **Rating Tier Selected:** _____

(if more than one available)

Broker: _____

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Plan Overview		
Plan ID	78124NY0980138-00	
Plan Name	SimplyBlue Plus Gold 5	
Plan Type	Copay	
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Plan features		
Primary Care Physician (PCP)	Not Required	
Referrals	Not Required	
Out of network benefits	Covered at 80%, subject to the deductible	
Out of area benefits	Coverage provided worldwide through the BlueCard program	
Student/Dependent coverage	Qualified dependents are covered to age 26	
Domestic partner	Covered	
Wellness Incentives	ExerciseRewards™ receive up to $600 a year toward qualified fitness facility dues	
Plan cost-sharing highlights		
Primary Care Office Visit	$40 copay per visit	Covered at 80%, subject to the deductible
Specialist Office Visit	$60 copay per visit	Covered at 80%, subject to the deductible
Coinsurance	None	Covered at 80%
Deductible	None	$500 Individual / $1,000 Family
Out of pocket maximum	$6,350 Individual / $12,700 Family	$6,350 Individual / $12,700 Family
Lifetime maximum	None	None
Plan Benefits		
Preventive Healthcare Services	**In-Network**	**Out-Of-Network**
Well child visits	Covered In Full	Covered at 80%, subject to the deductible
Adult routine physical exams	Covered In Full	Covered at 80%, subject to the deductible
+Adult immunizations	Covered In Full	Covered at 80%, subject to the deductible
+Mammography	Covered In Full	Covered at 80%, subject to the deductible
+Pap smear	Covered In Full	Covered at 80%, subject to the deductible
Routine GYN Exam	Covered In Full	Covered at 80%, subject to the deductible
+Prostate cancer screening	Covered In Full	Covered at 80%, subject to the deductible
+Colonoscopy	Preventive screenings covered in full	Covered at 80%, subject to the deductible
+Family Planning Services	Covered in full	Covered at 80%, subject to the deductible
Physician Office Services	**In-Network**	**Out-Of-Network**
Diagnostic office visits	$40 PCP copay; $60 Specialist copay per visit	Covered at 80%, subject to the deductible
Diagnostic x-rays	$60 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	$40 copay per visit	Covered at 80%, subject to the deductible
Allergy tests	$40 PCP copay; $60 Specialist copay per visit	Covered at 80%, subject to the deductible
Allergy injections	$40 PCP copay; $60 Specialist copay per visit	Covered at 80%, subject to the deductible
Chemotherapy	$40 copay per visit	Covered at 80%, subject to the deductible
Radiation therapy	$60 copay per visit	Covered at 80%, subject to the deductible
Maternity Services	**In-Network**	**Out-Of-Network**
Prenatal care	Covered In Full	Covered at 80%, subject to the deductible per admission
Hospital care for mom (including delivery)	Subject to $500 copay per admission	Covered at 80%, per admission, subject to the deductible
Newborn nursery care	Covered In Full	Covered at 80%, per admission, subject to the deductible
Prescription Drug	**In-Network**	**Out-Of-Network**
Prescription Drug Coverage	$5/$45/$90	Not Covered
Inpatient Hospital Benefits	**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
Physician visits in the hospital	Covered In Full	Covered at 80%, subject to the deductible per admission
Inpatient physical rehabilitation	Subject to $500 copay per admission for up to 60	Covered at 80%, per admission for up to 60 days per

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	days per condition per lifetime	condition per lifetime, subject to the deductible
Surgery	Covered In Full	Covered at 80%, subject to the deductible per admission
Anesthesia	Covered In Full	Covered at 80%, subject to the deductible per admission
Emergency Care	**In-Network**	**Out-Of-Network**
Emergency room care	$250 copay per visit	$250 copay per visit
Freestanding urgent care center	$60 copay per visit	Covered at 80%, subject to the deductible
Ambulance	$250 copay	$250 copay
Outpatient Hospital Benefits	**In-Network**	**Out-Of-Network**
Diagnostic x-rays	$60 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	$40 copay per visit	Covered at 80%, subject to the deductible
Surgical Care Facility Fee	$250 copay per visit	Covered at 80%, subject to the deductible
Chemotherapy	$40 copay per visit	Covered at 80%, subject to the deductible
Radiation Therapy	$60 copay per visit	Covered at 80%, subject to the deductible
Mental Health and Chemical Dependence	**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
Outpatient mental health care	$60 copay per visit	Covered at 80%, subject to the deductible
Inpatient chemical dependence	Subject to $500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible
Outpatient chemical dependence	$60 copay per visit	Covered at 80%, subject to the deductible
Other Services	**In-Network**	**Out-Of-Network**
Diabetic insulin and supplies	$40 copay per 30 day supply	Covered at 80%, 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
Home care	$40 copay per visit for 40 visits per year	Covered at 80%, 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
Outpatient therapy	$60 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
Durable medical equipment	Covered at 50%	Covered at 50%, subject to the deductible
External prosthetics	Covered at 50%	Covered at 50%, subject to the deductible
Chiropractic	$60 copay per visit	Covered at 80%, subject to the deductible
Acupuncture	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
Vision Benefits	**In-Network**	**Out-Of-Network**
Adult Routine Vision Exam	$60 copay per visit for one routine exam every year	Covered at 80% for one routine exam every year, subject to the deductible
Adult Diagnostic Vision	$60 copay per visit	Covered at 80%, subject to the deductible
Adult Eyewear	Eyewear Reimbursement of $60 per year	Eyewear Reimbursement of $60 per year
Pediatric Routine Vision Exam	$60 copay per visit for one routine exam every year	Covered at 80% 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
Dental Benefits	**In-Network**	**Out-Of-Network**
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Not Covered	Not Covered
Pediatric Major Dental Care & Medical Ortho	Not Covered	Not Covered
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