

## **Premium Rate Schedule & Contract Summary**

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

Version Updated: 09/25/2013

Plan ID: 78124NY0980042-00	Plan Name: SimplyBlue Plus Platinum 1	Enrollment Code: SBBP		
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	\$559.40			
Subscriber & Spouse	\$1,118.79			
Subscriber & Child(ren)	\$950.97			
Family	\$1,594.28			
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.				
	rate filing for quarterly community rates. All Rates will be considered to be on a 12 month p . The above rates are effective for the Initial Term of the Agreement. Rates for any Renewal			
A). Do you have dental coverage that includes mandated essential health pediatric dental benefits?  Yes No S  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 Eligib	ole:		
Coverage Effective Date:	Rating Tier Selected:			
	(if more than one available)			
Broker:				

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Plan ID	78124NY0980042-00		
Plan Name			
	SimplyBlue Plus Platinum 1		
Plan Type Quote Effective	Copay		
	01/01/2014 - 03/31/2014		
Plan features	Net De suite d		
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	\$15 copay per visit	Covered at 80%, subject to the deductible	
Specialist Office Visit	\$25 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	\$15 PCP copay; \$25 Specialist copay per visit	Covered at 80%, subject to the deductible	
Diagnostic x-rays	\$25 copay per visit	Covered at 80%, subject to the deductible	
Diagnostic laboratory and pathology	\$15 copay per visit	Covered at 80%, subject to the deductible	
Allergy tests	\$15 PCP copay; \$25 Specialist copay per visit	Covered at 80%, subject to the deductible	
Allergy injections	\$15 PCP copay; \$25 Specialist copay per visit	Covered at 80%, subject to the deductible	
Chemotherapy	\$15 copay per visit	Covered at 80%, subject to the deductible	
Radiation therapy	\$25 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 \$250 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/\$35/\$70	Not Covered	
Inpatient Hospital Benefits	In-Network	Out-Of-Network	
Hospital benefits	Subject to \$250 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 \$250 copay per admission for up to 60	Covered at 80%, per admission for up to 60 days per	

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0	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	\$150 copay per visit	\$150 copay per visit	
Freestanding urgent care center	\$25 copay per visit	Covered at 80%, subject to the deductible	
Ambulance	\$150 copay	\$150 copay	
Outpatient Hospital Benefits	In-Network	Out-Of-Network	
Diagnostic x-rays	\$25 copay per visit	Covered at 80%, subject to the deductible	
Diagnostic laboratory and pathology	\$15 copay per visit	Covered at 80%, subject to the deductible	
Surgical Care Facility Fee	\$150 copay per visit	Covered at 80%, subject to the deductible	
Chemotherapy	\$15 copay per visit	Covered at 80%, subject to the deductible	
Radiation Therapy	\$25 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 \$250 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	
Outpatient mental health care	\$25 copay per visit	Covered at 80%, subject to the deductible	
Inpatient chemical dependence	Subject to \$250 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	
Outpatient chemical dependence	\$25 copay per visit	Covered at 80%, subject to the deductible	
Other Services	In-Network	Out-Of-Network	
Diabetic insulin and supplies	\$15 copay per 30 day supply	Covered at 80%, subject to the deductible	
Skilled nursing facility	Subject to \$250 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	\$15 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 \$250 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	\$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	
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	\$25 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	\$25 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	\$25 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	\$25 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	\$150 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	

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. +Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. 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.