



**Premium Rate Schedule & Contract Summary**

**Quote Effective: 01/01/2015 - 03/31/2015**

**Version Updated: 10/23/2014**

<b>Plan ID: 78124NY0990089-00</b>	<b>Plan Name: SimplyBlue Plus Gold 14</b>	<b>Enrollment Code: SPPS</b>
<b>Rating Region: Utica</b>	<b>Small Group</b>	
<b>Rate</b>		
For the Benefits described in the Agreement, including the Certificate (identified below), the Plan will charge and Group will pay the following premium rates:		
<b>Subscriber Spouse/Subscriber Child(ren)/Family</b>		
<b>Single</b>	\$541.56	
<b>Subscriber &amp; Spouse</b>	\$1,083.14	
<b>Subscriber &amp; Child(ren)</b>	\$920.66	
<b>Family</b>	\$1,543.47	
Dependent Coverage To Age <b>26</b> , Pediatric Dental Coverage <b>Yes</b> , Domestic Partner Coverage <b>Yes</b> , Family Planning Coverage <b>Yes</b>		
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.		
<b>*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.</b>		
<b>Please complete this section if you have selected a plan that does not include pediatric dental coverage.</b>		
A). Have you obtained dental coverage, not offered by Excellus BCBS, that provides essential pediatric dental benefits through a NY State of Health certified dental plan? <b>Yes No</b>		
B.) If you answered 'yes', please provide the name of the company issuing the essential pediatric dental coverage. If you answered 'no' please be aware that the ACA requires essential pediatric dental coverage.		

[Application](#)

[Summary of Benefits & Coverage](#)

Summary of Benefits and Coverage (SBC) for this product has been received. Group is responsible for distributing the SBC to all eligible employees in accordance with PPACA requirements.

**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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<b>Plan Overview</b>		
Plan ID	78124NY0990089-00	
Plan Name	SimplyBlue Plus Gold 14	
Plan Highlights	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 & Deductible	
HSA Eligible	No	
Quote Effective	01/01/2015 - 03/31/2015	
<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 our BlueCard® Network	
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 and/or fitness classes	
<b>Plan cost-sharing highlights</b>		
Primary Care Office Visit	\$25 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Specialist Office Visit	\$40 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Coinsurance	Covered at 80%	Covered at 60%
Deductible	In-Network: \$1,000 Individual / \$2,000 Family	Out-of-Network: \$1,000 Individual / \$2,000 Family
Out of pocket maximum	In-Network: \$3,000 Individual / \$6,000 Family	Out-of-Network: \$3,000 Individual / \$6,000 Family
Lifetime maximum	None	None
<b>Plan Benefits</b>		
<b>Preventive Healthcare Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Well child visits	Covered In Full	Covered at 60%, subject to the deductible
Adult routine physical exams	Covered In Full	Covered at 60%, subject to the deductible
+Adult immunizations	Covered In Full	Covered at 60%, subject to the deductible
+Mammography	Covered In Full	Covered at 60%, subject to the deductible
+Pap smear	Covered In Full	Covered at 60%, subject to the deductible
Routine GYN Exam	Covered In Full	Covered at 60%, subject to the deductible
+Prostate cancer screening	Covered In Full	Covered at 60%, subject to the deductible
+Colonoscopy	Preventive screenings covered in full	Covered at 60%, subject to the deductible
+Family Planning Services	Covered in full	Covered at 60%, subject to the deductible
<b>Physician Office Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Diagnostic office visits	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Diagnostic x-rays	\$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	\$25 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Allergy tests	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Allergy injections	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Chemotherapy	\$25 PCP copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Radiation therapy	\$40 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>
Prenatal care	Covered In Full	Covered at 60%, subject to the deductible
Hospital care for mom (including delivery)	Covered at 80%, subject to the deductible	Covered at 60% per admission, subject to the deductible
Newborn nursery care	Covered In Full, subject to deductible	Covered at 60% per admission, subject to the

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		deductible
<b>Prescription Drug</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Prescription Drug Coverage</b>	\$5/\$25/\$50	Not Covered
<b>Inpatient Hospital Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Hospital benefits</b>	Covered at 80% per admission for unlimited days, subject to the deductible	Covered at 60%, per admission for unlimited days, subject to the deductible
<b>Physician visits in the hospital</b>	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
<b>Inpatient physical rehabilitation</b>	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
<b>Surgery</b>	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
<b>Anesthesia</b>	Covered at 80%, 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>	\$250 copay per visit, subject to deductible	\$250 copay per visit, subject to deductible
<b>Freestanding urgent care center</b>	\$40 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
<b>Ambulance</b>	\$250 copay per visit, subject to deductible	\$250 copay per visit, subject to deductible
<b>Outpatient Hospital Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Diagnostic x-rays</b>	\$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
<b>Diagnostic laboratory and pathology</b>	\$25 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
<b>Surgical Care Facility Fee</b>	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
<b>Chemotherapy</b>	\$25 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
<b>Radiation Therapy</b>	\$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
<b>Mental Health and Substance Use</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Inpatient mental health care</b>	Covered at 80% per admission for unlimited days, subject to the deductible	Covered at 60%, per admission for unlimited days, subject to the deductible
<b>Outpatient mental health care</b>	\$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
<b>Inpatient substance use</b>	Covered at 80% per admission for unlimited days, subject to the deductible	Covered at 60%, per admission for unlimited days, subject to the deductible
<b>Outpatient substance use</b>	\$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
<b>Other Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Diabetic insulin and supplies</b>	\$25 copay, subject to deductible per 30 day supply	Covered at 60%, subject to the deductible
<b>Skilled nursing facility</b>	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
<b>Home care</b>	\$25 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
<b>Hospice</b>	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
<b>Outpatient therapy</b>	\$40 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
<b>Durable medical equipment</b>	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
<b>External prosthetics</b>	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
<b>Chiropractic</b>	\$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
<b>Acupuncture</b>	Not Covered	Not Covered
<b>Hearing Aids</b>	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
<b>Vision Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Adult Routine Vision Exam</b>	\$40 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
<b>Adult Diagnostic Vision</b>	\$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
<b>Adult Eyewear</b>	Eyewear Reimbursement of \$60 per year	Eyewear Reimbursement of \$60 per year
<b>Pediatric Routine Vision Exam</b>	\$40 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
<b>Pediatric Eyewear</b>	Covered at 50%, subject to the deductible for one	Covered at 50%, subject to the deductible for one

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	purchase per year	purchase per year
Dental Benefits	In-Network	Out-of-Network
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	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%, subject to the deductible	Covered at 50%, subject to the deductible and balance billing
Accidental Dental - Outpatient Surgical	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

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.