Excellus

Premium Rate Schedule & Contract Summary

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

Version Updated: 10/23/2014

Plan ID: 78124NY0990057-00	**Plan Name: SimplyBlue Plus Gold 11**	**Enrollment Code: SOOM**
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	$555.91	
Subscriber & Spouse	$1,111.83	
Subscriber & Child(ren)	$945.06	
Family	$1,584.36	
Dependent Coverage To Age **26**, Pediatric Dental Coverage **Yes**, 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.**		
Please complete this section if you have selected a plan that does not include pediatric dental coverage. 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? **Yes** ☐ **No** ☐ 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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Plan Overview		
Plan ID	78124NY0990057-00	
Plan Name	SimplyBlue Plus Gold 11	
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	
Plan features		
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	
Plan cost-sharing highlights		
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: $500 Individual / $1,000 Family	Out-of-Network: $500 Individual / $1,000 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
Plan Benefits		
Preventive Healthcare Services	**In-Network**	**Out-of-Network**
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
Physician Office Services	**In-Network**	**Out-of-Network**
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
Maternity Services	**In-Network**	**Out-of-Network**
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
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	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 at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Inpatient physical rehabilitation	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 at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Anesthesia	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Emergency Care	**In-Network**	**Out-of-Network**
Emergency room care	$250 copay per visit, subject to deductible	$250 copay per visit, subject to deductible
Freestanding urgent care center	$40 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Ambulance	$250 copay per visit, subject to deductible	$250 copay per visit, subject to deductible
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**
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
Surgical Care Facility Fee	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Chemotherapy	$25 copay per visit, subject to the 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
Mental Health and Substance Use	**In-Network**	**Out-of-Network**
Inpatient mental health care	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	$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Inpatient substance use	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	$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Other Services	**In-Network**	**Out-of-Network**
Diabetic insulin and supplies	$25 copay, subject to deductible per 30 day supply	Covered at 60%, subject to the deductible
Skilled nursing facility	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	$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
Hospice	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	$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
Durable medical equipment	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
External prosthetics	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
Chiropractic	$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Acupuncture	Not Covered	Not Covered
Hearing Aids	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**
Adult Routine Vision Exam	$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
Adult Diagnostic Vision	$40 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
Pediatric Routine Vision Exam	$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
Pediatric Eyewear	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.