Excellus

Premium Rate Schedule & Contract Summary

Quoting Period: 01/01/2013 - 03/31/2013

Version Updated: 11/01/2012

SB-CD-16	SimplyBlue Copay and Deductible	
Rating Region: Rochester	**Small Group**	**Sole Proprietor**
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:		
4-Tier- Ind/Subscriber Spouse/Subscriber Child(ren)/Family		
Single	$432.43	$497.29
Sub w/Spouse	$1,055.20	$1,213.47
Sub w/Child	$890.31	$1,023.87
Sub w/Children	$890.31	$1,023.87
Sub w/Spouse and one or more Children	$1,134.31	$1,304.47
Rates quoted herein are subject to change due to our implementation of the provisions of the Federal Patient Protection and Affordable Care Act. Rates and benefits quoted herein are also subject to changes due to provisions of the Federal Mental Health Parity Addiction Equity Act (FMHPAEA) for groups that have an average of 51 or more total employees. FMHPAEA brings mental health and substance abuse benefits into parity with medical and surgical benefits. Groups subject to provisions of FMHPAEA may be required to make changes to their benefit plans to be in compliance with the law.		
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 Insurance has approved our rate filing for quarterly community rates effective January 1, 2011. 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.**		

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: _____

Master Group Agreement Template - Complete and submit with this Premium Rate Schedule

The Certificate consists of the following subscriber contracts, certificates, riders, and/or endorsements (form numbers and/or descriptions, including variables):

EXC-C-10 (Rev. 1) SimplyBlue Preferred Provider Organization Certificate of Coverage EXR-C-35 (Rev. 1) Diabetic Drugs, Supplies and Equipment Requiring Prior Authorization
EXR-C-48 (Rev. 1) Allowable expense rider EXR-C-49 SimplyBlue Cost Sharing Expenses and Routine Foot Care Exclusion Rider. EXR-C-56 SimplyBlue Colonoscopy Rider
EXHP-30 (Rev. 2) Dental Care Exclusion Rider EXHP-114 Rider for External Appeals involving Rare Diseases [and Prior Approval of Home Care Services]
EXHP-129 Rider for Coding Accuracy and Multiple Surgical Procedures EXHP-137 Patient Protection and Affordable Care Act Rider
EXHP-181 Rider for Parity in Mental Health and Substance Use Disorder Benefits EXHP-186 Rider to Continue Coverage for Young Adults Through age 29
EXHP-188 Rider to Extend Temporary Continuation of Coverage EXHP-195 Rider for Grievance Procedures and Transitional Care XX1 Annual Disclosure Notice
XX2 The New York Consumer Guide to Health Insurers XX4 Privacy Notice: How Medical Information may be used and Disclosed and how to Get Access to this Information.
EXR-C-31 Rider for Eye Wear and Hearing Aids EXR-C-3 Rider for Domestic Partner Coverage

EXR-C-33 (Rev. 2) Prescription Drug Rider EXR-C-51 Days' Supply Endorsement for Tier One Prescription EXR-107 Endorsement for Specialty Medication Pharmacy Network
EXR-121 (Rev. 1) List of Specialty Medications EXHP-110 Prescription Drugs Requiring Prior Authorization EXHP-92 Endorsement for Contraceptive Drugs and Devices

SB-CD-16	SimplyBlue Copay and Deductible	
Plan Overview		
Package ID	SB-CD-16	
Plan Name	SimplyBlue Copay and Deductible	
Plan Type	PPO	
Quoting Period	01/01/2013 - 03/31/2013	
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 the BlueCard program	
Student/Dependent coverage	Qualified dependents are covered to age 26	
Domestic partner	Covered	
Wellness Incentives	Blue365 - Exclusive access to information, discounts & savings	
Plan cost-sharing highlights		
Office visit copay (Primary Care Physician)	Adult: $30 copay per visit; Children to age 19: $0 copay per visit	
Office visit copay (Specialist)	$50 copay per visit	
Coinsurance	In network: Covered at 80%; Out of network: Covered at 60%	
Deductible	Combined in and out of network: $500 Individual / $1500 Family	
Out of pocket maximum	Combined in and out of network: $1500 Individual / $4500 Family	
Lifetime maximum	None	
Plan Benefits		
Preventive Healthcare Services	**In-Network**	**Out Of Network**
Well child visits	Covered in full	Covered in full
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 60%, subject to the deductible for one routine exam per year
+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
Routine vision	$50 copay for one routine exam every year. $60 eyewear allowance available per year	Covered at 60%, subject to the deductible for one routine exam per year. $60 eyewear allowance available per year
+Colonoscopy	Preventive screening covered in full	Covered at 60%, subject to the deductible
Physician Office Services	**In-Network**	**Out Of Network**
Diagnostic office visits	Adult: $30 copay per visit to your PCP; $50 copay per visit to a specialist. Child: $0 copay per visit to your PCP; $50 copay per visit to a specialist	Covered at 60%, subject to the deductible
Diagnostic x-rays	$50 copay per visit	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered at 60%, subject to the deductible
Allergy tests	Adult: $30 copay per visit to your PCP; $50 copay per visit to a specialist. Child: $0 copay per visit to your PCP; $50 copay per visit to a specialist	Covered at 60%, subject to the deductible
Allergy injections	Adult: $30 copay per visit to your PCP; $50 copay per visit to a specialist. Child: $0 copay per visit to your PCP; $50 copay per visit to a specialist	Covered at 60%, subject to the deductible
Chemotherapy	$30 copay per visit	Covered at 60%, subject to the deductible
Radiation therapy	$50 copay per visit	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%, subject to the deductible
Newborn nursery care	Covered in full	Covered at 60%, subject to the deductible
Prescription Drug	**In-Network**	**Out Of Network**
Short-term and maintenance drugs	$5/$35/$70; $0 copay for generics for children to age 19	Not covered

SB-CD-16	SimplyBlue Copay and Deductible	
Inpatient Hospital Benefits	**In-Network**	**Out Of Network**
Hospital benefits	Covered at 80%, subject to the deductible	Covered at 60%, 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%, subject to the deductible for up to 60 days per year	Covered at 60%, subject to the deductible for up to 60 days per year
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 80%, subject to the deductible
Emergency Care	**In-Network**	**Out Of Network**
Emergency room care	$250 copay per visit, unless admitted within 24 hours	$250 copay per visit, unless admitted within 24 hours
Freestanding urgent care center	$50 copay per visit	Covered at 60%, subject to the deductible
Ambulance	$250 copay	$250 copay
Outpatient Hospital Benefits	**In-Network**	**Out Of Network**
Diagnostic x-rays	$50 copay per visit	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered at 60%, subject to the deductible
Surgical care	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Chemotherapy	$30 copay per visit	Covered at 60%, subject to the deductible
Radiation Therapy	$50 copay per visit	Covered at 60%, subject to the deductible
Mental Health and Chemical Dependence	**In-Network**	**Out Of Network**
Inpatient mental health care	Covered at 80%, subject to the deductible for up to 30 days per year	Covered at 60%, subject to the deductible for up to 30 days per year
Outpatient mental health care	$50 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office	Covered at 60%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider's office
Inpatient chemical dependence	Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime	Covered at 60%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime
Outpatient chemical dependence	$50 copay per visit for up to 60 visits per year	Covered at 60%, subject to the deductible for up to 60 visits per year
Other Services	**In-Network**	**Out Of Network**
Diabetic insulin and supplies	$30 copay for up to a 30 day supply	Covered at 60%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Covered at 80%, subject to the deductible for up to 45 days per year	Covered at 60%, subject to the deductible for up to 45 days per year
Home care	Covered in full for up to 40 visits per year	Covered at 75%, subject to a $50 deductible for up to 40 visits per year
Hospice	Covered in full for unlimited days	Covered at 60%, subject to the deductible for unlimited visits per year
Outpatient therapy	$50 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 60%, subject to the deductible for a combined total of 45 visits per year for physical, speech, and occupational therapy
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	$50 copay per visit	Covered at 60%, subject to the deductible
Acupuncture	$50 copay for up to 10 visits per year	Covered at 60%, subject to the deductible, for up to 10 visits per year
Dental	$50 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	$50 copay for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years	Covered at 60%, subject to the deductible, for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years

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.