Excellus BlueCross BlueShield

National strength.
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Individual care.™

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Quote Effective: 04/01/2017 - 06/30/2017

Version Updated: 01/23/2017

Rating Region: Rochester

	SimplyBlue Plus Gold 18	
Plan Overview		
Plan ID	78124NY0990265-00	
Plan Name	SimplyBlue Plus Gold 18	
Plan Highlights	A deductible is applied to select covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full. Plan includes ExerciseRewards.	
Plan Type	Hybrid	
HSA Eligible	No	
Quote Effective	04/01/2017 - 06/30/2017	
Rate ($)	**Small Group**	
Single	$519.76	
Subscriber & Spouse	$1,039.52	
Subscriber & Child(ren)	$883.59	
Family	$1,481.32	
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		
Plan cost-sharing highlights	**In-Network**	**Out-of-Network**
Primary Care Office Visit	$30 copay per visit	Covered at 60%, subject to the deductible
Specialist Office Visit	$50 copay per visit	Covered at 60%, subject to the deductible

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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: $4,000 Individual / $8,000 Family	Out-of-Network: $4,000 Individual / $8,000 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	$30 PCP copay; $50 Specialist copay per visit	Covered at 60%, subject to the deductible
Telemedicine Visits	$30 PCP copay; $50 Specialist copay per visit. MDLive Provider: $10 copay per visit	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	$30 copay per visit	Covered at 60%, subject to the deductible
Allergy tests	$30 PCP copay; $50 Specialist copay per visit	Covered at 60%, subject to the deductible
Allergy injections	$30 PCP copay; $50 Specialist copay per visit	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 (Cost share may apply to ultrasounds, lab work and sick visits)	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 at 80%, subject to the deductible	Covered at 60%, 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	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	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible

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hospital		
Inpatient physical rehabilitation	Covered at 80% per 60 day stay per admission per contract year, subject to the deductible	Covered at 60% per 60 day stay per admission per contract year, 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	$250 copay per visit
Freestanding urgent care center	$50 copay per visit	Covered at 60%, subject to the deductible
Ambulance	$250 copay per visit	$250 copay per visit
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	$30 copay per visit	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	$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 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	$50 copay per visit	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	$50 copay per visit	Covered at 60%, subject to the deductible
Other Services	**In-Network**	**Out-of-Network**
Diabetic drugs, insulin, and supplies	$30 copay 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 200 days per year, subject to the deductible
Home care	Covered at 80% for up to 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	$50 for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 60%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year
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	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**

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Adult Routine Vision Exam	$50 copay per visit for one routine exam every year	Covered at 60% for one routine exam every year, subject to the deductible
Adult Diagnostic Vision	$50 copay per visit	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	$50 copay per visit for one routine exam every year	Covered at 60% for one routine exam every year, subject to the deductible
Pediatric Eyewear	Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 50%, subject to the deductible for one purchase per plan year
Dental Benefits	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Preventive covered at 100%. Routine covered at 80%, subject to the deductible	Preventive covered at 100%, subject to balance billing. Routine 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.