**Quote Effective: 01/01/2019 - 03/31/2019**

**Version Updated: 09/12/2018**

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|---|---|
| **Print Package: HIOS ID (Enrollment Code)** | **78124NY0990297-00 (SOI7)** |
| **Plan Name:** | **SimplyBlue Plus Gold 19** |
| **Rating Region:** | **Rochester** |
| **Rate** | |
| **For the Benefits described in the Agreement, the Plan will charge and Group will pay the following premium rates:** | |
| Single | $555.69 |
| Subscriber & Spouse | $1,111.38 |
| Subscriber & Child(ren) | $944.67 |
| Family | $1,583.72 |
| 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.**<br>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?<br>**Yes** ☐ **No** ☐<br>B.) If you answered 'yes', please provide the name of the company issuing the essential pediatric dental coverage. _____<br>If you answered 'no' please be aware 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:** _____

**Broker:** _____

| | SimplyBlue Plus Gold 19 | |
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| **Plan Overview** | | |
| Plan ID | 78124NY0990297-00 (SOI7) | |
| Plan Name | SimplyBlue Plus Gold 19 | |
| Aggregation Design | Individual Aggregation | |
| 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, includes ExerciseRewards. | |
| Plan Type | Hybrid | |
| HSA Eligible | No | |
| Quote Effective | 01/01/2019 - 03/31/2019 | |
| **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 $600 a year toward qualified fitness facility dues and/or fitness classes and save on Gym memberships with Active&Fit Direct™. | |
| **Plan cost-sharing highlights** | | |
| **Plan cost-sharing highlights** | **In-Network** | **Out-of-Network** |
| Primary Care Office Visit | $40 copay per visit | Covered at 60%, subject to the deductible |
| Specialist Office Visit | $60 copay per visit | Covered at 60%, subject to the deductible |
| Coinsurance | Covered at 80% | Covered at 60% |
| Deductible | In-Network: $2,250 Individual / $4,500 Family | Out-of-Network: $2,250 Individual / $4,500 Family |
| Out of pocket maximum | In-Network: $6,850 Individual / $13,700 Family | Out-of-Network: $6,850 Individual / $13,700 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 |

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| +Family Planning Services | Covered in full | Covered at 60%, subject to the deductible |
| **Physician Office Services** | **In-Network** | **Out-of-Network** |
| Diagnostic office visits | $40 PCP copay; $60 Specialist copay per visit | Covered at 60%, subject to the deductible |
| Telemedicine Visits | $40 PCP copay; $60 Specialist copay per visit. MDLive Provider: $10 copay per visit | Covered at 60%, subject to the deductible |
| Diagnostic x-rays | $60 copay per visit | Covered at 60%, subject to the deductible |
| Advanced Imaging Services | $100 copay per visit | Covered at 60%, subject to the deductible |
| Diagnostic laboratory and pathology | $40 copay per visit | Covered at 60%, subject to the deductible |
| Allergy tests | $40 PCP copay; $60 Specialist copay per visit | Covered at 60%, subject to the deductible |
| Allergy injections | $40 PCP copay; $60 Specialist copay per visit | Covered at 60%, subject to the deductible |
| Chemotherapy | $40 copay per visit | Covered at 60%, subject to the deductible |
| Radiation therapy | $60 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 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 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 | $350 copay per visit | $350 copay per visit |
| Freestanding urgent care center | $60 copay per visit | Covered at 60%, subject to the deductible |
| Ambulance | $350 copay per visit | $350 copay per visit |
| **Outpatient Hospital Benefits** | **In-Network** | **Out-of-Network** |
| Diagnostic x-rays | $60 copay per visit | Covered at 60%, subject to the deductible |
| Advanced Imaging Services | $100 copay per visit | Covered at 60%, subject to the deductible |

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|---|---|---|
| Diagnostic laboratory and pathology | $40 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 | $40 copay per visit | Covered at 60%, subject to the deductible |
| Radiation Therapy | $60 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 | $60 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 | $60 copay per visit | Covered at 60%, subject to the deductible |
| **Other Services** | **In-Network** | **Out-of-Network** |
| Diabetic drugs, insulin, and supplies | $40 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 | $60 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 | $60 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** |
| Adult Routine Vision Exam | $60 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 | $60 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 | $60 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 - | Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or | Covered at 60% for accidental injury to sound, natural teeth and for care due to congenital disease or |

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| Outpatient Surgical | anomaly, subject to the deductible | 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.**