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**Premium Rate Schedule & Contract Summary**

**Quote Effective: 01/01/2018 - 12/31/2018**

**Version Updated: 10/16/2017**

<b>Plan ID: 78124NY0910002-00</b>	<b>Plan Name: Base</b>	<b>Enrollment Code: IKKX</b>
<b>Rating Region: Rochester</b>	<b>Direct Pay</b>	
<b>Rate</b>		
<b>Plan Name: Base</b>		
<b>Plan Highlights</b>	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ExerciseRewards.	
<b>Network Structure</b>	This plan provides covered benefits at 100% of hospitals and more than 98% of local doctors in our 31-county network.	
<b>Enrollment Code</b>	IKKX	
<b>Plan Type</b>	Deductible	
<b>HSA Eligibility</b>	No	
<b>Monthly Premium Single \$207.72 / Subscriber &amp; Spouse \$415.44 / Subscriber &amp; Children \$353.12 / Family \$592.00</b>		
<b>In-Network Benefits</b>		
<b>Deductible</b>	\$7,350 Individual / \$14,700 Family	
<b>Coinsurance</b>	None	
<b>Annual Out of Pocket Maximum</b>	\$7,350 Individual / \$14,700 Family	
<b>Primary Care / Specialist Office Visit</b>	Covered at 100%, subject to the deductible / Covered at 100%, subject to the deductible	
<b>Hospital Benefit</b>	Covered at 100% per admission for unlimited days, subject to the deductible	
<b>Emergency Room Care</b>	Covered at 100%, subject to the deductible	
<b>Urgent Care</b>	Covered at 100%, subject to the deductible	
<b>Prescription Drug</b>	\$0, subject to the plan deductible	
Dependent Coverage To Age <b>26</b> , Pediatric Dental Coverage <b>Not Included</b>		
A summary of benefits and coverage (SBC) can be found at <a href="http://excellusbcbs.com/sbcfinder">excellusbcbs.com/sbcfinder</a> , or you can call 1-855-646-8011 to request a copy to be mailed to you. You will need to key in the Plan ID# listed above.		
<b>How To enroll:</b> Complete the enrollment application included and mail to: Excellus Health Plan, Inc P.O. Box 22999 Rochester, NY 14692		
Questions? Call <b>1-888-477-5804</b> Our dedicated insurance advisors can help complete your enrollment application and answer your questions.		
<b>Tips For Enrolling:</b>		
<ul style="list-style-type: none"> <li>• Carefully review the entire enrollment application to make sure it's filled out. An incomplete form will be returned and will delay your enrollment.</li> <li>• Sign the completed enrollment form.</li> <li>• Enclose a check or money order for the first month's premium made payable to Excellus Health Plan. The monthly premium amount you owe is shown above.</li> <li>• <b>Payment must be received and processed before the plan will become effective.</b></li> </ul>		

78124NY0910002-00		Base
<b>Plan Overview</b>		
Plan ID	78124NY0910002-00	
Plan Name	Base	
Plan Highlights	No	
Plan Type	Deductible	
HSA Eligible	No	
Quote Effective	01/01/2018 - 12/31/2018	
<b>Plan features</b>		
Primary Care Physician (PCP)	Not Required	
Referrals	Not Required	
Out of network benefits	Not Covered	
Out of area benefits	worldwide through our BlueCard®	
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	Covered at 100%, subject to the deductible	Not Covered
Specialist Office Visit	Covered at 100%, subject to the deductible	Not Covered
Coinsurance	None	None
Deductible	\$7,350 Individual / \$14,700 Family	None
Out of pocket maximum	\$7,350 Individual / \$14,700 Family	None
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	Not Covered
Adult routine physical exams	Covered In Full	Not Covered
+Adult immunizations	Covered In Full	Not Covered
+Mammography	Covered In Full	Not Covered
+Pap smear	Covered In Full	Not Covered
Routine GYN Exam	Covered In Full	Not Covered
+Prostate cancer screening	Covered In Full	Not Covered
+Colonoscopy	Preventive screenings covered in full	Not Covered
+Family Planning Services	Covered In Full	Not Covered
<b>Physician Office Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Diagnostic office visits	3 primary visits covered in full. Next visits covered at 100%, subject to the deductible	Not Covered
Diagnostic x-rays	Covered at 100%, subject to the deductible	Not Covered
Diagnostic laboratory and pathology	Covered at 100%, subject to the deductible	Not Covered
Allergy tests	Covered at 100%, subject to the deductible	Not Covered
Allergy injections	Covered at 100%, subject to the deductible	Not Covered
Chemotherapy	Covered at 100%, subject to the deductible	Not Covered
Radiation therapy	Covered at 100%, subject to the deductible	Not Covered
<b>Maternity Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Prenatal care	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Not Covered
Hospital care for mom (including delivery)	Covered at 100%, subject to the deductible	Not Covered
Newborn nursery care	Covered at 100%, subject to the deductible	Not Covered
<b>Prescription Drug</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Short-term and maintenance drugs	\$0, subject to the plan deductible	Not Covered

78124NY0910002-00		
	Base	
Inpatient Hospital Benefits	In-Network	Out-of-Network
Hospital benefits	Covered at 100% per admission for unlimited days, subject to the deductible	Not Covered
Physician visits in the hospital	Covered at 100%, subject to the deductible	Not Covered
Inpatient physical rehabilitation	Covered at 100% per 60 day stay per admission per calendar year, subject to the deductible	Not Covered
Surgery	Covered at 100%, subject to the deductible	Not Covered
Anesthesia	Covered at 100%, subject to the deductible	Not Covered
Emergency Care	In-Network	Out-of-Network
Emergency room care	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Freestanding urgent care center	Covered at 100%, subject to the deductible	Not Covered
Ambulance	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Outpatient Hospital Benefits	In-Network	Out-of-Network
Diagnostic x-rays	Covered at 100%, subject to the deductible	Not Covered
Diagnostic laboratory and pathology	Covered at 100%, subject to the deductible	Not Covered
Surgical Care Facility Fee	Covered at 100%, subject to the deductible	Not Covered
Chemotherapy	Covered at 100%, subject to the deductible	Not Covered
Radiation Therapy	Covered at 100%, subject to the deductible	Not Covered
Mental Health and Substance Use	In-Network	Out-of-Network
Inpatient mental health care	Covered at 100% per admission for unlimited days, subject to the deductible	Not Covered
Outpatient mental health care	Covered at 100%, subject to the deductible	Not Covered
Inpatient substance use	Covered at 100% per admission for unlimited days, subject to the deductible	Not Covered
Outpatient substance use	Covered at 100%, subject to the deductible	Not Covered
Other Services	In-Network	Out-of-Network
Diabetic insulin and supplies	Covered at 100%, subject to the deductible per 30 day supply	Not Covered
Skilled nursing facility	Covered at 100% per admission for 200 days per year, subject to the deductible	Not Covered
Home care	Covered at 100% for up to 40 visits per year, subject to the deductible	Not Covered
Hospice	Covered at 100% for up to 210 visits per year, subject to the deductible	Not Covered
Outpatient therapy	Covered at 100%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per calendar year	Not Covered
Durable medical equipment	Covered at 100%, subject to the deductible	Not Covered
External prosthetics	Covered at 100%, subject to the deductible	Not Covered
Chiropractic	Covered at 100%, subject to the deductible	Not Covered
Acupuncture	Not Covered	Not Covered
Hearing Aids	Covered at 100%, subject to the deductible for a single purchase once every 3 years	Not Covered
Vision Benefits	In-Network	Out-of-Network
Routine vision	Not Covered	Not Covered
Adult Diagnostic Vision	Covered at 100%, subject to the deductible	Not Covered
Adult Eyewear	Not Covered	Not Covered
Pediatric Routine Vision Exam	Covered at 100% for one routine exam per plan year, subject to the deductible	Not Covered
Pediatric Eyewear	Covered at 100%, subject to the deductible	Not Covered
Dental Benefits	In-Network	Out-of-Network
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Not Covered	Not Covered

78124NY0910002-00	Base	
Pediatric Major Dental Care & Medical Ortho	Not Covered	Not Covered
Accidental Dental - Outpatient Surgical	Covered at 100% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Not Covered

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.