Excellus | National strength. Local focus. Individual care.™

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Premium Rate Schedule & Contract Summary

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

Version Updated: 10/16/2017

Plan ID: 78124NY0890016-00	**Plan Name: Gold Select**	**Enrollment Code: IJJV**
Rating Region: Rochester	**Direct Pay**	
Rate		
Plan Name: Gold Select		
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.	
Network Structure	This plan provides covered benefits at 100% of hospitals and more than 98% of local doctors in our 31-county network.	
Enrollment Code	IJJV	
Plan Type	Hybrid	
HSA Eligibility	No	
Monthly Premium Single $593.19 / Subscriber & Spouse $1,186.38 / Subscriber & Children $1,008.42 / Family $1,690.59		
In-Network Benefits		
Deductible	$750 Individual / $1,500 Family	
Coinsurance	None	
Annual Out of Pocket Maximum	$6,350 Individual / $12,700 Family	
Primary Care / Specialist Office Visit	$25 copay per visit, subject to deductible / $40 copay per visit, subject to deductible	
Hospital Benefit	Subject to $750 copay per admission for unlimited days, subject to the deductible	
Emergency Room Care	$250 copay per visit, subject to deductible	
Urgent Care	$40 copay per visit, subject to deductible	
Prescription Drug	$10/$35/$70	
Dependent Coverage To Age **26**, Pediatric Dental Coverage **Not Included**		
A summary of benefits and coverage (SBC) can be found at excellususbcbs.com/sbcfinder, 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.		
How To enroll: Complete the enrollment application included and mail to: Excellus Health Plan, Inc P.O. Box 22999 Rochester, NY 14692		
Questions? Call **1-888-477-5804** Our dedicated insurance advisors can help complete your enrollment application and answer your questions.		
Tips For Enrolling: • Carefully review the entire enrollment application to make sure it's filled out. An incomplete form will be returned and will delay your enrollment. • Sign the completed enrollment form. • 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. • **Payment must be received and processed before the plan will become effective.**		

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Plan Overview		
Plan ID	78124NY0890016-00	
Plan Name	Gold Select	
Plan Highlights	No	
Plan Type	Hybrid	
HSA Eligible	No	
Quote Effective	01/01/2018 - 12/31/2018	
Plan features		
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	
Plan cost-sharing highlights		
Primary Care Office Visit	$25 copay per visit, subject to deductible	Not Covered
Specialist Office Visit	$40 copay per visit, subject to deductible	Not Covered
Coinsurance	None	None
Deductible	$750 Individual / $1,500 Family	None
Out of pocket maximum	$6,350 Individual / $12,700 Family	None
Lifetime maximum	None	None
Plan Benefits		
Preventive Healthcare Services	**In-Network**	**Out-of-Network**
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
Physician Office Services	**In-Network**	**Out-of-Network**
Diagnostic office visits	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Diagnostic x-rays	$40 copay per visit, subject to the deductible	Not Covered
Diagnostic laboratory and pathology	$40 copay per visit, subject to the deductible	Not Covered
Allergy tests	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Allergy injections	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Chemotherapy	$25 PCP copay per visit, subject to deductible	Not Covered
Radiation therapy	$40 copay per visit, subject to the deductible	Not Covered
Maternity Services	**In-Network**	**Out-of-Network**
Prenatal care	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Not Covered
Hospital care for mom (including delivery)	Subject to $750 copay, subject to the deductible	Not Covered
Newborn nursery care	Covered In Full, subject to deductible	Not Covered
Prescription Drug	**In-Network**	**Out-of-Network**

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Short-term and maintenance drugs	$10/$35/$70	Not Covered
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Hospital benefits	Subject to $750 copay 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	Subject to $750 copay 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	$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	Not Covered
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	Not Covered
Diagnostic laboratory and pathology	$40 copay per visit, subject to the deductible	Not Covered
Surgical Care Facility Fee	Covered at 100%, subject to the deductible	Not Covered
Chemotherapy	$25 copay per visit, subject to the deductible	Not Covered
Radiation Therapy	$40 copay per visit, subject to the deductible	Not Covered
Mental Health and Substance Use	**In-Network**	**Out-of-Network**
Inpatient mental health care	Subject to $750 copay per admission for unlimited days, subject to the deductible	Not Covered
Outpatient mental health care	$40 copay per visit, subject to the deductible	Not Covered
Inpatient substance use	Subject to $750 copay per admission for unlimited days, subject to the deductible	Not Covered
Outpatient substance use	$40 copay per visit, subject to the deductible	Not Covered
Other Services	**In-Network**	**Out-of-Network**
Diabetic insulin and supplies	$25 copay, subject to deductible per 30 day supply	Not Covered
Skilled nursing facility	Subject to $750 copay per admission for 200 days per year, subject to the deductible	Not Covered
Home care	$25 copay per visit for 40 visits per year, subject to the deductible	Not Covered
Hospice	Subject to $750 copay for up to 210 visits per year, subject to the deductible	Not Covered
Outpatient therapy	$40 per visit, subject to deductible for physical, speech and occupational therapy for up to 60 visits per calendar year	Not Covered
Durable medical equipment	Covered at 50%, subject to the deductible	Not Covered
External prosthetics	Covered at 50%, subject to the deductible	Not Covered
Chiropractic	$40 copay per visit, subject to the deductible	Not Covered
Acupuncture	Not Covered	Not Covered
Hearing Aids	Covered at 50% , 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	$40 copay per visit, subject to the deductible	Not Covered
Adult Eyewear	Not Covered	Not Covered
Pediatric Routine Vision Exam	$40 copay per visit for one routine exam per plan year, subject to deductible	Not Covered
Pediatric Eyewear	Covered at 50%, subject to the deductible for one purchase per year	Not Covered
Dental Benefits	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered

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Pediatric Dental: Preventative & Routine	Not Covered	Not Covered
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.