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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: 09/15/2017

Plan ID: 78124NY0880009-00	Plan Name: Platinum Select	Enrollment Code: IJJQ
Rating Region: Rochester	Direct Pay	
Rate		
Plan Name: Platinum Select		
Plan Highlights	Predictable out-of-pocket costs without a deductible, 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	IJJQ	
Plan Type	Copay	
HSA Eligibility	No	
Monthly Premium Single \$699.23 / Subscriber & Spouse \$1,398.46 / Subscriber & Children \$1,188.69 / Family \$1,992.81		
In-Network Benefits		
Deductible	None	
Coinsurance	None	
Annual Out of Pocket Maximum	\$6,350 Individual / \$12,700 Family	
Primary Care / Specialist Office Visit	\$15 copay per visit / \$25 copay per visit	
Hospital Benefit	Subject to \$750 copay per admission for unlimited days	
Emergency Room Care	\$150 copay per visit	
Urgent Care	\$25 copay per visit	
Prescription Drug	\$10/\$35/\$70	
Dependent Coverage To Age 26 , Pediatric Dental Coverage Included		
A summary of benefits and coverage (SBC) can be found at excellusbcbs.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:		
<ul style="list-style-type: none"> • 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	78124NY0880009-00	
Plan Name	Platinum Select	
Plan Highlights	No	
Plan Type	Copay	
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	\$15 copay per visit	Not Covered
Specialist Office Visit	\$25 copay per visit	Not Covered
Coinsurance	None	None
Deductible	None	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	\$15 PCP copay; \$25 Specialist copay per visit	Not Covered
Diagnostic x-rays	\$25 copay per visit	Not Covered
Diagnostic laboratory and pathology	\$25 copay per visit	Not Covered
Allergy tests	\$15 PCP copay; \$25 Specialist copay per visit	Not Covered
Allergy injections	\$15 PCP copay; \$25 Specialist copay per visit	Not Covered
Chemotherapy	\$15 copay per visit	Not Covered
Radiation therapy	\$25 copay per visit	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 per admission	Not Covered
Newborn nursery care	Covered In Full	Not Covered
Prescription Drug	In-Network	Out-of-Network
Short-term and maintenance drugs	\$10/\$35/\$70	Not Covered
Inpatient Hospital Benefits	In-Network	Out-of-Network

78124NY0880009-00		Platinum Select
Hospital benefits	Subject to \$750 copay per admission for unlimited days	Not Covered
Physician visits in the hospital	Covered In Full	Not Covered
Inpatient physical rehabilitation	Subject to \$750 copay per admission for up to 60 days per calendar year	Not Covered
Surgery	Covered In Full	Not Covered
Anesthesia	Covered In Full	Not Covered
Emergency Care	In-Network	Out-of-Network
Emergency room care	\$150 copay per visit	\$150 copay per visit
Freestanding urgent care center	\$25 copay per visit	Not Covered
Ambulance	\$150 copay	\$150 copay
Outpatient Hospital Benefits	In-Network	Out-of-Network
Diagnostic x-rays	\$25 copay per visit	Not Covered
Diagnostic laboratory and pathology	\$25 copay per visit	Not Covered
Surgical Care Facility Fee	\$150 copay per visit	Not Covered
Chemotherapy	\$15 copay per visit	Not Covered
Radiation Therapy	\$25 copay per visit	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	Not Covered
Outpatient mental health care	\$25 copay per visit	Not Covered
Inpatient substance use	Subject to \$750 copay per admission for unlimited days	Not Covered
Outpatient substance use	\$25 copay per visit	Not Covered
Other Services	In-Network	Out-of-Network
Diabetic insulin and supplies	\$15 copay per 30 day supply	Not Covered
Skilled nursing facility	Subject to \$750 copay per admission for up to 200 days per year	Not Covered
Home care	\$15 copay per visit for 40 visits per year	Not Covered
Hospice	Subject to \$750 copay per admission for up to 210 days per year	Not Covered
Outpatient therapy	\$25 per visit for physical, speech and occupational therapy for up to 60 visits per calendar year	Not Covered
Durable medical equipment	Covered at 50%	Not Covered
External prosthetics	Covered at 50%	Not Covered
Chiropractic	\$25 copay per visit	Not Covered
Acupuncture	Not Covered	Not Covered
Hearing Aids	Covered at 50% 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	\$25 copay per visit	Not Covered
Adult Eyewear	Not Covered	Not Covered
Pediatric Routine Vision Exam	\$25 copay per visit for one routine exam per plan year	Not Covered
Pediatric Eyewear	Covered at 50% for one purchase per year	Not Covered
Dental Benefits	In-Network	Out-of-Network
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Covered at 80%	Not Covered
Pediatric Major Dental Care & Medical Ortho	Covered at 50%	Not Covered
Accidental Dental - Outpatient Surgical	\$150 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease	Not Covered

78124NY0880009-00	Platinum Select	
	or anomaly	

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.