Excellus BlueCross BlueShield

National strength.
Local focus.
Individual care.™

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Rating Region: Rochester
Quote Effective: 01/01/2016 - 03/31/2016
Version Updated: 10/22/2015

Plan ID	78124NY0980105-00		78124NY0980025-00		78124NY1110009-00	
Enrollment Code	SCX7		SFC3		SGL1	
Plan Name	SimplyBlue Plus Gold 3		SimplyBlue Plus Platinum 2		Healthy New York EPO	
Plan Highlights	Predictable out-of-pocket costs without a deductible, includes ExerciseRewards.		Predictable out-of-pocket costs without a deductible, includes ExerciseRewards.		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.	
Plan Type	Copay		Copay		Hybrid	
HSA Eligible	No		No		No	
Quote Effective	01/01/2016 - 03/31/2016		01/01/2016 - 03/31/2016		01/01/2016 - 03/31/2016	
Rate ($)	**Small Group**		**Small Group**		**Small Group**	
Subscriber Spouse/Subscriber Child(ren)/Family						
Single	$474.00		$551.19		$296.96	
Subscriber & Spouse	$948.01		$1,102.38		$593.93	
Subscriber & Child(ren)	$805.81		$937.03		$504.84	
Family	$1,350.91		$1,570.89		$846.35	
Plan features						
Primary Care Physician (PCP)	Not Required		Not Required		Not Required	
Referrals	Not Required		Not Required		Not Required	
Out of network benefits	Covered at 80%, subject to the deductible		Covered at 80%, subject to the deductible		Not Covered	
Out of area benefits	Coverage provided worldwide through our BlueCard® Network		Coverage provided worldwide through our BlueCard® Network		Coverage provided worldwide through our BlueCard® Network	
Student/Dependent coverage	Qualified dependents are covered to age 26		Qualified dependents are covered to age 26		Qualified dependents are covered to age 26	
Domestic partner	Covered		Covered		Covered	
Wellness Incentives	ExerciseRewards™ receive up to $600 a year toward qualified fitness facility dues and/or fitness classes		ExerciseRewards™ receive up to $600 a year toward qualified fitness facility dues and/or fitness classes		ExerciseRewards™ receive up to $600 a year toward qualified fitness facility dues and/or fitness classes	
Plan cost-sharing highlights	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Primary Care Office Visit	$30 copay per visit	Covered at 80%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit, subject to deductible	Not Covered
Specialist Office Visit	$50 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit	Covered at 80%, subject to the deductible	$40 copay per visit, subject to deductible	Not Covered

Coinsurance	None	Covered at 80%	None	Covered at 80%	Covered at 100%	Not Covered
Deductible	None	Out-of-Network: $500 Individual / $1,000 Family	None	Out-of-Network: $500 Individual / $1,000 Family	In-Network: $600 Individual / $1,200 Family	Not Covered
Out of pocket maximum	In-Network: $6,350 Individual / $12,700 Family	Out-of-Network: $6,350 Individual / $12,700 Family	In-Network: $6,350 Individual / $12,700 Family	Out-of-Network: $6,350 Individual / $12,700 Family	In-Network: $4,000 Individual / $8,000 Family	Not Covered
Lifetime maximum	None	None	None	None	None	None
Preventive Healthcare Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Well child visits	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Not Covered
Adult routine physical exams	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Not Covered
+Adult immunizations	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Not Covered
+Mammography	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Not Covered
+Pap smear	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Not Covered
Routine GYN Exam	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Not Covered
+Prostate cancer screening	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Not Covered
+Colonoscopy	Preventive screenings covered in full	Covered at 80%, subject to the deductible	Preventive screenings covered in full	Covered at 80%, subject to the deductible	Preventive screenings covered in full	Not Covered
+Family Planning Services	Covered in full	Covered at 80%, subject to the deductible	Covered in full	Covered at 80%, subject to the deductible	Covered in full	Not Covered
Physician Office Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic office visits	$30 PCP copay; $50 Specialist copay per visit	Covered at 80%, subject to the deductible	$15 PCP copay; $25 Specialist copay per visit	Covered at 80%, subject to the deductible	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Diagnostic x-rays	$50 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit	Covered at 80%, subject to the deductible	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Diagnostic laboratory and pathology	$50 copay per visit	Covered at 80%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Allergy tests	$30 PCP copay; $50 Specialist copay per visit	Covered at 80%, subject to the deductible	$15 PCP copay; $25 Specialist copay per visit	Covered at 80%, subject to the deductible	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Allergy injections	$30 PCP copay; $50 Specialist copay per visit	Covered at 80%, subject to the deductible	$15 PCP copay; $25 Specialist copay per visit	Covered at 80%, subject to the deductible	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Chemotherapy	$30 copay per visit	Covered at 80%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible	$25 PCP copay per visit, subject to deductible	Not Covered
Radiation therapy	$50 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit	Covered at 80%, subject to the deductible	$25 PCP copay per visit, subject to deductible	Not Covered
Maternity Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prenatal care	Covered In Full	Covered at 80%, subject to the deductible per admission	Covered In Full	Covered at 80%, subject to the deductible per admission	Covered In Full	Not Covered
Hospital care for mom (including delivery)	Subject to $750 copay per admission	Covered at 80%, per admission, subject to the deductible	Subject to $150 copay per admission	Covered at 80%, per admission, subject to the deductible	Subject to $1000 copay per admission, subject to the deductible	Not Covered

Newborn nursery care	Covered In Full	Covered at 80%, per admission, subject to the deductible	Covered In Full	Covered at 80%, per admission, subject to the deductible	Covered In Full, subject to deductible	Not Covered
Prescription Drug	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Coverage	$15/$50/50%	Not Covered	$5/$25/$50	Not Covered	$10/$35/$70	Not Covered
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital benefits	Subject to $750 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to $150 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to $1000 copay per admission for unlimited days, subject to the deductible	Not Covered
Physician visits in the hospital	Covered In Full	Covered at 80%, subject to the deductible per admission	Covered In Full	Covered at 80%, subject to the deductible per admission	Covered In Full	Not Covered
Inpatient physical rehabilitation	Subject to $750 copay per admission for up to 60 days per condition per lifetime	Covered at 80%, per admission for up to 60 days per condition per lifetime, subject to the deductible	Subject to $150 copay per admission for up to 60 days per condition per lifetime	Covered at 80%, per admission for up to 60 days per condition per lifetime, subject to the deductible	Subject to $1000 copay per admission for up to 60 days per condition per lifetime, subject to the deductible	Not Covered
Surgery	Covered In Full	Covered at 80%, subject to the deductible per admission	Covered In Full	Covered at 80%, subject to the deductible per admission	$100 copay per visit, subject to deductible	Not Covered
Anesthesia	Covered In Full	Covered at 80%, subject to the deductible per admission	Covered In Full	Covered at 80%, subject to the deductible per admission	Covered In Full	Not Covered
Emergency Care	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency room care	$350 copay per visit	$350 copay per visit	$75 copay per visit	$75 copay per visit	$150 copay per visit, subject to deductible	$150 copay per visit, subject to deductible
Freestanding urgent care center	$50 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit	Covered at 80%, subject to the deductible	$60 copay per visit, subject to deductible	Not Covered
Ambulance	$350 copay	$350 copay	$75 copay	$75 copay	$150 copay per visit, subject to deductible	$150 copay per visit, subject to deductible
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic x-rays	$50 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit	Covered at 80%, subject to the deductible	$40 copay per visit, subject to the deductible	Not Covered
Diagnostic laboratory and pathology	$50 copay per visit	Covered at 80%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible	$40 copay per visit, subject to the deductible	Not Covered
Surgical Care Facility Fee	$350 copay per visit	Covered at 80%, subject to the deductible	$75 copay per visit	Covered at 80%, subject to the deductible	$100 copay per visit; subject to deductible	Not Covered
Chemotherapy	$30 copay per visit	Covered at 80%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit, subject to the deductible	Not Covered
Radiation Therapy	$50 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit, subject to the deductible	Not Covered
Mental Health and Substance Use	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient mental health care	Subject to $750 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to $150 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to $1000 copay per admission for unlimited days, subject to the deductible	Not Covered
Outpatient mental health care	$50 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit, subject to the deductible	Not Covered
Inpatient substance use	Subject to $750 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to $150 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to $1000 copay per admission for unlimited days, subject to the deductible	Not Covered
Outpatient substance use	$50 copay per visit	Covered at 80%, subject to the	$25 copay per visit	Covered at 80%, subject to the	$25 copay per visit, subject to the	Not Covered

		deductible		deductible	deductible	
Other Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diabetic insulin and supplies	$30 copay per 30 day supply	Covered at 80%, subject to the deductible	$15 copay per 30 day supply	Covered at 80%, subject to the deductible	$25 copay, subject to deductible per 30 day supply	Not Covered
Skilled nursing facility	Subject to $750 copay per admission for up to 200 days per year	Covered at 80%, per admission for up to 200 days per year, subject to the deductible	Subject to $150 copay per admission for up to 200 days per year	Covered at 80%, per admission for up to 200 days per year, subject to the deductible	Subject to $1000 copay per admission for up to 200 days per year, subject to the deductible	Not Covered
Home care	$30 copay per visit for 40 visits per year	Covered at 80%, for up to 40 visits per year, subject to the deductible	$15 copay per visit for 40 visits per year	Covered at 80%, for up to 40 visits per year, subject to the deductible	$25 copay per visit for 40 visits per year, subject to the deductible	Not Covered
Hospice	Subject to $750 copay per admission for up to 210 days per year	Covered at 80%, for up to 210 days per year, subject to the deductible	Subject to $150 copay per admission for up to 210 days per year	Covered at 80%, for up to 210 days per year, subject to the deductible	Subject to $1000 copay per admission for up to 210 days per year, subject to the deductible	Not Covered
Outpatient therapy	$50 per visit for physical, speech and occupational therapy for up to 60 visits per condition per lifetime	Covered at 80%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per condition per lifetime	$25 per visit for physical, speech and occupational therapy for up to 60 visits per condition per lifetime	Covered at 80%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per condition per lifetime	$30 per visit, subject to deductible for physical, speech and occupational therapy for up to 60 visits per condition per lifetime	Not Covered
Durable medical equipment	Covered at 50%	Covered at 50%, subject to the deductible	Covered at 50%	Covered at 50%, subject to the deductible	Covered at 80%, subject to the deductible	Not Covered
External prosthetics	Covered at 50%	Covered at 50%, subject to the deductible	Covered at 50%	Covered at 50%, subject to the deductible	Covered at 80%, subject to the deductible	Not Covered
Chiropractic	$50 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit	Covered at 80%, subject to the deductible	$40 Specialist copay per visit, subject to deductible	Not Covered
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Aids	Covered at 50% for a single purchase once every 3 years	Covered at 50%, subject to the deductible for a single purchase once every 3 years	Covered at 50% for a single purchase once every 3 years	Covered at 50%, subject to the deductible for a single purchase once every 3 years	Covered at 80% , subject to the deductible for a single purchase once every 3 years	Not Covered
Vision Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Routine Vision Exam	$50 copay per visit for one routine exam every year	Covered at 80% for one routine exam every year, subject to the deductible	$25 copay per visit for one routine exam every year	Covered at 80% for one routine exam every year, subject to the deductible	Not Covered	Not Covered
Adult Diagnostic Vision	$50 copay per visit	Covered at 80%, subject to the deductible	$25 copay per visit	Covered at 80%, subject to the deductible	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Adult Eyewear	Eyewear Reimbursement of $60 per year	Eyewear Reimbursement of $60 per year	Eyewear Reimbursement of $60 per year	Eyewear Reimbursement of $60 per year	Not Covered	Not Covered
Pediatric Routine Vision Exam	$50 copay per visit for one routine exam every year	Covered at 80% for one routine exam every year, subject to the deductible	$25 copay per visit for one routine exam every year	Covered at 80% for one routine exam every year, subject to the deductible	$25 copay per visit for one routine exam every year, subject to the deductible	Not Covered
Pediatric Eyewear	Covered at 50% for one purchase per plan year	Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 50% for one purchase per plan year	Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 80%, subject to the deductible for one purchase per plan year	Not Covered
Dental Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Preventive covered at 100%. Routine covered at 80%	Preventive covered at 100%, subject to balance billng. Routine covered at 80%,subject to the deductible and balance billing	Preventive covered at 100%. Routine covered at 80%	Preventive covered at 100%, subject to balance billng. Routine covered at 80%,subject to the deductible and balance billing	$25 per visit, subject to deductible	Not Covered
Pediatric Major Dental Care & Medical Ortho	Covered at 50%	Covered at 50%, subject to the deductible and balance billing	Covered at 50%	Covered at 50%, subject to the deductible and balance billing	$25 per visit, subject to deductible	Not Covered

Accidental Dental - Outpatient Surgical	$350 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	$75 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	$100 copay per visit 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 nor a Summary of Benefits and Coverage (SBC). This benefit summary is intended to highlight the coverage of this program. Benefits are determined by the terms of the Member Certificate. All benefits are subject to medical necessity.
+When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA appropriate cost share for the service will be applied. 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.

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