

**Excellus Health Plans, Inc  
dba**

**Excellus BCBS, Univera Healthcare**

**Individual Market  
Off-Exchange**

**Documentation in Support of  
New York State  
Section 4308(c) Rate Submission**

**Rate Manual  
Effective January 1, 2015**

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**Rate Manual Pages**

**Excellus Health Plan, Inc.**

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2015

Community Rated

**2015 Individual Premium Rates -Rochester Region**

Option	HIOS Plan ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880004	533.73	1,067.44	907.33	1,521.11	NA
Excellus BCBS Platinum Select	78124NY0880010	534.44	1,068.89	908.55	1,523.17	NA
Excellus BCBS Gold Standard	78124NY0890004	462.69	925.38	786.57	1,318.67	NA
Excellus BCBS Silver Standard	78124NY0890010	400.76	801.53	681.31	1,142.18	NA
Excellus BCBS Gold Select	78124NY0890016	463.81	927.62	788.47	1,321.85	NA
Excellus BCBS Bronze Standard	78124NY0900004	314.59	629.19	534.81	896.59	NA
Excellus BCBS Silver Select	78124NY0900010	370.28	740.57	629.49	1,055.31	NA
Excellus BCBS Bronze Select	78124NY0900014	295.83	591.66	502.91	843.11	NA
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS Platinum Standard	78124NY0880002	543.87	1,087.72	924.56	1,550.01	NA
Excellus BCBS Platinum Select	78124NY0880008	544.60	1,089.19	925.81	1,552.10	NA
Excellus BCBS Gold Standard	78124NY0890002	471.48	942.97	801.52	1,343.72	NA
Excellus BCBS Silver Standard	78124NY0890008	408.38	816.75	694.25	1,163.88	NA
Excellus BCBS Gold Select	78124NY0890014	472.62	945.25	803.45	1,346.97	NA
Excellus BCBS Bronze Standard	78124NY0900002	320.57	641.14	544.97	913.63	NA
Excellus BCBS Silver Select	78124NY0900008	377.32	754.63	641.44	1,075.36	NA
Excellus BCBS Bronze Select	78124NY0900012	301.45	602.91	512.46	859.13	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880003	539.12	1,078.21	916.48	1,536.47	NA
Excellus BCBS Platinum Select	78124NY0880009	539.26	1,078.54	916.75	1,536.92	NA
Excellus BCBS Gold Standard	78124NY0890003	467.62	935.22	794.93	1,332.69	NA
Excellus BCBS Silver Standard	78124NY0890009	405.45	810.89	689.27	1,155.51	NA
Excellus BCBS Gold Select	78124NY0890015	468.63	937.28	796.68	1,335.61	NA
Excellus BCBS Bronze Standard	78124NY0900003	317.63	635.27	539.98	905.26	NA
Excellus BCBS Silver Select	78124NY0900009	375.11	750.22	637.69	1,069.07	NA
Excellus BCBS Bronze Select	78124NY0900013	300.65	601.32	511.11	856.87	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS Platinum Standard	78124NY0880001	549.36	1,098.70	933.89	1,565.66	NA
Excellus BCBS Platinum Select	78124NY0880007	549.51	1,099.04	934.17	1,566.12	NA
Excellus BCBS Gold Standard	78124NY0890001	476.50	952.99	810.04	1,358.01	NA
Excellus BCBS Silver Standard	78124NY0890007	413.15	826.30	702.37	1,177.47	NA
Excellus BCBS Gold Select	78124NY0890013	477.53	955.09	811.81	1,360.98	NA
Excellus BCBS Bronze Standard	78124NY0900001	323.67	647.34	550.24	922.46	NA
Excellus BCBS Silver Select	78124NY0900007	382.23	764.48	649.80	1,089.38	NA
Excellus BCBS Bronze Select	78124NY0900011	306.36	612.75	520.82	873.15	NA
<b><u>EXEC-2 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880006	NA	NA	NA	NA	219.89
Excellus BCBS Gold Standard	78124NY0890006	NA	NA	NA	NA	190.63
Excellus BCBS Silver Standard	78124NY0890012	NA	NA	NA	NA	165.12
Excellus BCBS Bronze Standard	78124NY0900006	NA	NA	NA	NA	129.61
<b><u>EXEC-2 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880005	NA	NA	NA	NA	222.11
Excellus BCBS Gold Standard	78124NY0890005	NA	NA	NA	NA	192.65
Excellus BCBS Silver Standard	78124NY0890011	NA	NA	NA	NA	167.04
Excellus BCBS Bronze Standard	78124NY0900005	NA	NA	NA	NA	130.87
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090004	538.32	1,076.64	915.14	1,534.21	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090002	548.55	1,097.10	932.54	1,563.36	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090003	543.71	1,087.41	924.30	1,549.56	NA

**Excellus Health Plan, Inc.**

Excellus BlueCross BlueShield / Univera Healthcare

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**2015 Individual Premium Rates -Rochester Region**

Option	HIOS Plan ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090001	554.04	1,108.07	941.86	1,579.00	NA
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	221.79
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	224.01

**Excellus Health Plan, Inc.**

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**2015 Individual Premium Rates - Syracuse Region**

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880004	661.51	1,323.01	1,124.56	1,885.30	NA
Excellus BCBS Platinum Select	78124NY0880010	662.40	1,324.80	1,126.08	1,887.84	NA
Excellus BCBS Gold Standard	78124NY0890004	573.47	1,146.94	974.90	1,634.39	NA
Excellus BCBS Silver Standard	78124NY0890010	496.72	993.43	844.42	1,415.64	NA
Excellus BCBS Gold Select	78124NY0890016	574.86	1,149.71	977.26	1,638.34	NA
Excellus BCBS Bronze Standard	78124NY0900004	389.91	779.82	662.85	1,111.25	NA
Excellus BCBS Silver Select	78124NY0900010	458.94	917.88	780.20	1,307.98	NA
Excellus BCBS Bronze Select	78124NY0900014	366.66	733.31	623.31	1,044.98	NA
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS Platinum Standard	78124NY0880002	674.08	1,348.15	1,145.92	1,921.13	NA
Excellus BCBS Platinum Select	78124NY0880008	674.98	1,349.98	1,147.47	1,923.71	NA
Excellus BCBS Gold Standard	78124NY0890002	584.37	1,168.73	993.42	1,665.45	NA
Excellus BCBS Silver Standard	78124NY0890008	506.15	1,012.30	860.47	1,442.54	NA
Excellus BCBS Gold Select	78124NY0890014	585.78	1,171.56	995.83	1,669.47	NA
Excellus BCBS Bronze Standard	78124NY0900002	397.32	794.64	675.45	1,132.37	NA
Excellus BCBS Silver Select	78124NY0900008	467.66	935.31	795.02	1,332.83	NA
Excellus BCBS Bronze Select	78124NY0900012	373.63	747.24	635.16	1,064.83	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880003	668.19	1,336.37	1,135.90	1,904.33	NA
Excellus BCBS Platinum Select	78124NY0880009	668.38	1,336.77	1,136.24	1,904.90	NA
Excellus BCBS Gold Standard	78124NY0890003	579.56	1,159.13	985.26	1,651.77	NA
Excellus BCBS Silver Standard	78124NY0890009	502.52	1,005.03	854.28	1,432.17	NA
Excellus BCBS Gold Select	78124NY0890015	580.84	1,161.68	987.42	1,655.39	NA
Excellus BCBS Bronze Standard	78124NY0900003	393.68	787.36	669.27	1,121.99	NA
Excellus BCBS Silver Select	78124NY0900009	464.92	929.84	790.37	1,325.03	NA
Excellus BCBS Bronze Select	78124NY0900013	372.64	745.28	633.48	1,062.03	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS Platinum Standard	78124NY0880001	680.88	1,361.76	1,157.49	1,940.51	NA
Excellus BCBS Platinum Select	78124NY0880007	681.08	1,362.17	1,157.83	1,941.08	NA
Excellus BCBS Gold Standard	78124NY0890001	590.58	1,181.15	1,003.97	1,683.16	NA
Excellus BCBS Silver Standard	78124NY0890007	512.06	1,024.13	870.52	1,459.38	NA
Excellus BCBS Gold Select	78124NY0890013	591.87	1,183.75	1,006.18	1,686.84	NA
Excellus BCBS Bronze Standard	78124NY0900001	401.17	802.32	681.98	1,143.31	NA
Excellus BCBS Silver Select	78124NY0900007	473.75	947.51	805.38	1,350.21	NA
Excellus BCBS Bronze Select	78124NY0900011	379.72	759.44	645.52	1,082.21	NA
<b><u>EXEC-2 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880006	NA	NA	NA	NA	272.54
Excellus BCBS Gold Standard	78124NY0890006	NA	NA	NA	NA	236.27
Excellus BCBS Silver Standard	78124NY0890012	NA	NA	NA	NA	204.65
Excellus BCBS Bronze Standard	78124NY0900006	NA	NA	NA	NA	160.64
<b><u>EXEC-2 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880005	NA	NA	NA	NA	275.29
Excellus BCBS Gold Standard	78124NY0890005	NA	NA	NA	NA	238.79
Excellus BCBS Silver Standard	78124NY0890011	NA	NA	NA	NA	207.04
Excellus BCBS Bronze Standard	78124NY0900005	NA	NA	NA	NA	162.19
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS CNY Preferred Gold	78124NY1130004	530.08	1,060.17	901.14	1,510.75	NA
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS CNY Preferred Gold	78124NY1130002	540.16	1,080.31	918.27	1,539.45	NA
<b><u>EXEC-4 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS CNY Preferred Gold	78124NY1130003	536.07	1,072.13	911.31	1,527.80	NA

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<b><u>EXEC-4 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b> Excellus BCBS CNY Preferred Gold	78124NY1130001	546.25	1,092.50	928.63	1,556.83	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090004	667.20	1,334.41	1,134.24	1,901.53	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090002	679.88	1,359.77	1,155.79	1,937.66	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090003	673.88	1,347.77	1,145.59	1,920.56	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090001	686.68	1,373.38	1,167.35	1,957.05	NA
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	274.89
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	277.64

**Excellus Health Plan, Inc.**

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**2015 Individual Premium Rates - Utica/Watertown Region**

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880004	703.45	1,406.88	1,195.85	2,004.81	NA
Excellus BCBS Platinum Select	78124NY0880010	704.39	1,408.78	1,197.46	2,007.52	NA
Excellus BCBS Gold Standard	78124NY0890004	609.82	1,219.64	1,036.70	1,737.99	NA
Excellus BCBS Silver Standard	78124NY0890010	528.20	1,056.40	897.95	1,505.37	NA
Excellus BCBS Gold Select	78124NY0890016	611.30	1,222.60	1,039.21	1,742.19	NA
Excellus BCBS Bronze Standard	78124NY0900004	414.63	829.26	704.87	1,181.70	NA
Excellus BCBS Silver Select	78124NY0900010	488.03	976.07	829.66	1,390.90	NA
Excellus BCBS Bronze Select	78124NY0900014	389.90	779.81	662.83	1,111.22	NA
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental], EXER-1 (Rev.1)</u></b>						
Excellus BCBS Platinum Standard	78124NY0880002	716.81	1,433.62	1,218.58	2,042.90	NA
Excellus BCBS Platinum Select	78124NY0880008	717.77	1,435.55	1,220.21	2,045.66	NA
Excellus BCBS Gold Standard	78124NY0890002	621.41	1,242.82	1,056.39	1,771.01	NA
Excellus BCBS Silver Standard	78124NY0890008	538.24	1,076.47	915.01	1,533.97	NA
Excellus BCBS Gold Select	78124NY0890014	622.92	1,245.82	1,058.96	1,775.29	NA
Excellus BCBS Bronze Standard	78124NY0900002	422.50	845.01	718.26	1,204.15	NA
Excellus BCBS Silver Select	78124NY0900008	497.30	994.61	845.42	1,417.32	NA
Excellus BCBS Bronze Select	78124NY0900012	397.31	794.62	675.42	1,132.32	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880003	710.54	1,421.08	1,207.92	2,025.04	NA
Excellus BCBS Platinum Select	78124NY0880009	710.74	1,421.51	1,208.27	2,025.66	NA
Excellus BCBS Gold Standard	78124NY0890003	616.31	1,232.62	1,047.72	1,756.47	NA
Excellus BCBS Silver Standard	78124NY0890009	534.37	1,068.74	908.44	1,522.96	NA
Excellus BCBS Gold Select	78124NY0890015	617.66	1,235.32	1,050.03	1,760.33	NA
Excellus BCBS Bronze Standard	78124NY0900003	418.64	837.28	711.68	1,193.12	NA
Excellus BCBS Silver Select	78124NY0900009	494.39	988.79	840.47	1,409.04	NA
Excellus BCBS Bronze Select	78124NY0900013	396.26	792.53	673.64	1,129.36	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental], EXER-1 (Rev.1)</u></b>						
Excellus BCBS Platinum Standard	78124NY0880001	724.04	1,448.08	1,230.87	2,063.52	NA
Excellus BCBS Platinum Select	78124NY0880007	724.24	1,448.52	1,231.23	2,064.15	NA
Excellus BCBS Gold Standard	78124NY0890001	628.02	1,256.03	1,067.62	1,789.84	NA
Excellus BCBS Silver Standard	78124NY0890007	544.52	1,089.05	925.70	1,551.89	NA
Excellus BCBS Gold Select	78124NY0890013	629.40	1,258.79	1,069.98	1,793.78	NA
Excellus BCBS Bronze Standard	78124NY0900001	426.59	853.19	725.20	1,215.79	NA
Excellus BCBS Silver Select	78124NY0900007	503.78	1,007.58	856.44	1,435.81	NA
Excellus BCBS Bronze Select	78124NY0900011	403.79	807.59	686.44	1,150.81	NA
<b><u>EXEC-2 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880006	NA	NA	NA	NA	289.82
Excellus BCBS Gold Standard	78124NY0890006	NA	NA	NA	NA	251.25
Excellus BCBS Silver Standard	78124NY0890012	NA	NA	NA	NA	217.62
Excellus BCBS Bronze Standard	78124NY0900006	NA	NA	NA	NA	170.82
<b><u>EXEC-2 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880005	NA	NA	NA	NA	292.75
Excellus BCBS Gold Standard	78124NY0890005	NA	NA	NA	NA	253.93
Excellus BCBS Silver Standard	78124NY0890011	NA	NA	NA	NA	220.17
Excellus BCBS Bronze Standard	78124NY0900005	NA	NA	NA	NA	172.48
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Bassett Preferred Gold	78124NY0920004	529.22	1,058.45	899.67	1,508.29	NA
Excellus BCBS Bassett Preferred Silver	78124NY0920008	463.60	927.19	788.11	1,321.25	NA
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental], EXER-1 (Rev.1)</u></b>						
Excellus BCBS Bassett Preferred Gold	78124NY0920002	539.28	1,078.56	916.76	1,536.94	NA
Excellus BCBS Bassett Preferred Silver	78124NY0920006	472.40	944.81	803.08	1,346.35	NA

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<b><u>EXEC-4 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Bassett Preferred Gold	78124NY0920003	535.58	1,071.17	910.49	1,526.43	NA
Excellus BCBS Bassett Preferred Silver	78124NY0920007	469.95	939.92	798.92	1,339.39	NA
<b><u>EXEC-4 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS Bassett Preferred Gold	78124NY0920001	545.76	1,091.52	927.79	1,555.43	NA
Excellus BCBS Bassett Preferred Silver	78124NY0920005	478.89	957.77	814.10	1,364.84	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090004	709.50	1,419.00	1,206.14	2,022.08	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090002	722.98	1,445.97	1,229.06	2,060.49	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090003	716.60	1,433.20	1,218.21	2,042.31	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090001	730.22	1,460.43	1,241.36	2,081.11	NA
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	292.32
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	295.25

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<b><u>EXEC-1 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880004	703.45	1,406.88	1,195.85	2,004.81	NA
Excellus BCBS Platinum Select	78124NY0880010	704.39	1,408.78	1,197.46	2,007.52	NA
Excellus BCBS Gold Standard	78124NY0890004	609.82	1,219.64	1,036.70	1,737.99	NA
Excellus BCBS Silver Standard	78124NY0890010	528.20	1,056.40	897.95	1,505.37	NA
Excellus BCBS Gold Select	78124NY0890016	611.30	1,222.60	1,039.21	1,742.19	NA
Excellus BCBS Bronze Standard	78124NY0900004	414.63	829.26	704.87	1,181.70	NA
Excellus BCBS Silver Select	78124NY0900010	488.03	976.07	829.66	1,390.90	NA
Excellus BCBS Bronze Select	78124NY0900014	389.90	779.81	662.83	1,111.22	NA
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS Platinum Standard	78124NY0880002	716.81	1,433.62	1,218.58	2,042.90	NA
Excellus BCBS Platinum Select	78124NY0880008	717.77	1,435.55	1,220.21	2,045.66	NA
Excellus BCBS Gold Standard	78124NY0890002	621.41	1,242.82	1,056.39	1,771.01	NA
Excellus BCBS Silver Standard	78124NY0890008	538.24	1,076.47	915.01	1,533.97	NA
Excellus BCBS Gold Select	78124NY0890014	622.92	1,245.82	1,058.96	1,775.29	NA
Excellus BCBS Bronze Standard	78124NY0900002	422.50	845.01	718.26	1,204.15	NA
Excellus BCBS Silver Select	78124NY0900008	497.30	994.61	845.42	1,417.32	NA
Excellus BCBS Bronze Select	78124NY0900012	397.31	794.62	675.42	1,132.32	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880003	710.54	1,421.08	1,207.92	2,025.04	NA
Excellus BCBS Platinum Select	78124NY0880009	710.74	1,421.51	1,208.27	2,025.66	NA
Excellus BCBS Gold Standard	78124NY0890003	616.31	1,232.62	1,047.72	1,756.47	NA
Excellus BCBS Silver Standard	78124NY0890009	534.37	1,068.74	908.44	1,522.96	NA
Excellus BCBS Gold Select	78124NY0890015	617.66	1,235.32	1,050.03	1,760.33	NA
Excellus BCBS Bronze Standard	78124NY0900003	418.64	837.28	711.68	1,193.12	NA
Excellus BCBS Silver Select	78124NY0900009	494.39	988.79	840.47	1,409.04	NA
Excellus BCBS Bronze Select	78124NY0900013	396.26	792.53	673.64	1,129.36	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS Platinum Standard	78124NY0880001	724.04	1,448.08	1,230.87	2,063.52	NA
Excellus BCBS Platinum Select	78124NY0880007	724.24	1,448.52	1,231.23	2,064.15	NA
Excellus BCBS Gold Standard	78124NY0890001	628.02	1,256.03	1,067.62	1,789.84	NA
Excellus BCBS Silver Standard	78124NY0890007	544.52	1,089.05	925.70	1,551.89	NA
Excellus BCBS Gold Select	78124NY0890013	629.40	1,258.79	1,069.98	1,793.78	NA
Excellus BCBS Bronze Standard	78124NY0900001	426.59	853.19	725.20	1,215.79	NA
Excellus BCBS Silver Select	78124NY0900007	503.78	1,007.58	856.44	1,435.81	NA
Excellus BCBS Bronze Select	78124NY0900011	403.79	807.59	686.44	1,150.81	NA
<b><u>EXEC-2 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880006	NA	NA	NA	NA	289.82
Excellus BCBS Gold Standard	78124NY0890006	NA	NA	NA	NA	251.25
Excellus BCBS Silver Standard	78124NY0890012	NA	NA	NA	NA	217.62
Excellus BCBS Bronze Standard	78124NY0900006	NA	NA	NA	NA	170.82
<b><u>EXEC-2 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880005	NA	NA	NA	NA	292.75
Excellus BCBS Gold Standard	78124NY0890005	NA	NA	NA	NA	253.93
Excellus BCBS Silver Standard	78124NY0890011	NA	NA	NA	NA	220.17
Excellus BCBS Bronze Standard	78124NY0900005	NA	NA	NA	NA	172.48
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090004	709.50	1,419.00	1,206.14	2,022.08	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090002	722.98	1,445.97	1,229.06	2,060.49	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090003	716.60	1,433.20	1,218.21	2,042.31	NA

**Excellus Health Plan, Inc.**

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2015

Community Rated

**2015 Individual Premium Rates -Albany Region**

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090001	730.22	1,460.43	1,241.36	2,081.11	NA
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	292.32
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b> Excellus BCBS IND Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	295.25

**Excellus Health Plan, Inc.**

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2015

Community Rated

**2015 Individual Premium Rates - Mid-Hudson Region**

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880004	703.45	1,406.88	1,195.85	2,004.81	NA
Excellus BCBS Platinum Select	78124NY0880010	704.39	1,408.78	1,197.46	2,007.52	NA
Excellus BCBS Gold Standard	78124NY0890004	609.82	1,219.64	1,036.70	1,737.99	NA
Excellus BCBS Silver Standard	78124NY0890010	528.20	1,056.40	897.95	1,505.37	NA
Excellus BCBS Gold Select	78124NY0890016	611.30	1,222.60	1,039.21	1,742.19	NA
Excellus BCBS Bronze Standard	78124NY0900004	414.63	829.26	704.87	1,181.70	NA
Excellus BCBS Silver Select	78124NY0900010	488.03	976.07	829.66	1,390.90	NA
Excellus BCBS Bronze Select	78124NY0900014	389.90	779.81	662.83	1,111.22	NA
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS Platinum Standard	78124NY0880002	716.81	1,433.62	1,218.58	2,042.90	NA
Excellus BCBS Platinum Select	78124NY0880008	717.77	1,435.55	1,220.21	2,045.66	NA
Excellus BCBS Gold Standard	78124NY0890002	621.41	1,242.82	1,056.39	1,771.01	NA
Excellus BCBS Silver Standard	78124NY0890008	538.24	1,076.47	915.01	1,533.97	NA
Excellus BCBS Gold Select	78124NY0890014	622.92	1,245.82	1,058.96	1,775.29	NA
Excellus BCBS Bronze Standard	78124NY0900002	422.50	845.01	718.26	1,204.15	NA
Excellus BCBS Silver Select	78124NY0900008	497.30	994.61	845.42	1,417.32	NA
Excellus BCBS Bronze Select	78124NY0900012	397.31	794.62	675.42	1,132.32	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880003	710.54	1,421.08	1,207.92	2,025.04	NA
Excellus BCBS Platinum Select	78124NY0880009	710.74	1,421.51	1,208.27	2,025.66	NA
Excellus BCBS Gold Standard	78124NY0890003	616.31	1,232.62	1,047.72	1,756.47	NA
Excellus BCBS Silver Standard	78124NY0890009	534.37	1,068.74	908.44	1,522.96	NA
Excellus BCBS Gold Select	78124NY0890015	617.66	1,235.32	1,050.03	1,760.33	NA
Excellus BCBS Bronze Standard	78124NY0900003	418.64	837.28	711.68	1,193.12	NA
Excellus BCBS Silver Select	78124NY0900009	494.39	988.79	840.47	1,409.04	NA
Excellus BCBS Bronze Select	78124NY0900013	396.26	792.53	673.64	1,129.36	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS Platinum Standard	78124NY0880001	724.04	1,448.08	1,230.87	2,063.52	NA
Excellus BCBS Platinum Select	78124NY0880007	724.24	1,448.52	1,231.23	2,064.15	NA
Excellus BCBS Gold Standard	78124NY0890001	628.02	1,256.03	1,067.62	1,789.84	NA
Excellus BCBS Silver Standard	78124NY0890007	544.52	1,089.05	925.70	1,551.89	NA
Excellus BCBS Gold Select	78124NY0890013	629.40	1,258.79	1,069.98	1,793.78	NA
Excellus BCBS Bronze Standard	78124NY0900001	426.59	853.19	725.20	1,215.79	NA
Excellus BCBS Silver Select	78124NY0900007	503.78	1,007.58	856.44	1,435.81	NA
Excellus BCBS Bronze Select	78124NY0900011	403.79	807.59	686.44	1,150.81	NA
<b><u>EXEC-2 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880006	NA	NA	NA	NA	289.82
Excellus BCBS Gold Standard	78124NY0890006	NA	NA	NA	NA	251.25
Excellus BCBS Silver Standard	78124NY0890012	NA	NA	NA	NA	217.62
Excellus BCBS Bronze Standard	78124NY0900006	NA	NA	NA	NA	170.82
<b><u>EXEC-2 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Platinum Standard	78124NY0880005	NA	NA	NA	NA	292.75
Excellus BCBS Gold Standard	78124NY0890005	NA	NA	NA	NA	253.93
Excellus BCBS Silver Standard	78124NY0890011	NA	NA	NA	NA	220.17
Excellus BCBS Bronze Standard	78124NY0900005	NA	NA	NA	NA	172.48
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Bassett Preferred Gold	78124NY0920004	529.22	1,058.45	899.67	1,508.29	NA
Excellus BCBS Bassett Preferred Silver	78124NY0920008	463.60	927.19	788.11	1,321.25	NA
Excellus BCBS CNY Preferred Gold	78124NY1130004	NA	NA	NA	NA	NA
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS Bassett Preferred Gold	78124NY0920002	539.28	1,078.56	916.76	1,536.94	NA
Excellus BCBS Bassett Preferred Silver	78124NY0920006	472.40	944.81	803.08	1,346.35	NA

**Excellus Health Plan, Inc.**

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Premium Rates - Mid-Hudson Region**

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<b><u>EXEC-4 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS Bassett Preferred Gold	78124NY0920003	535.58	1,071.17	910.49	1,526.43	NA
Excellus BCBS Bassett Preferred Silver	78124NY0920007	469.95	939.92	798.92	1,339.39	NA
<b><u>EXEC-4 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS Bassett Preferred Gold	78124NY0920001	545.76	1,091.52	927.79	1,555.43	NA
Excellus BCBS Bassett Preferred Silver	78124NY0920005	478.89	957.77	814.10	1,364.84	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090004	709.50	1,419.00	1,206.14	2,022.08	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090002	722.98	1,445.97	1,229.06	2,060.49	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090003	716.60	1,433.20	1,218.21	2,042.31	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090001	730.22	1,460.43	1,241.36	2,081.11	NA
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	292.32
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b>						
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	295.25

**Excelsus Health Plan, Inc.**

Excelsus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2015

Community Rated

**2015 Individual Premium Rates - Buffalo Region**

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental]</u></b>						
Univera Platinum Standard	78124NY0930004	683.79	1,367.58	1,162.44	1,948.80	NA
Univera Platinum Select	78124NY0930010	684.71	1,369.42	1,164.01	1,951.43	NA
Univera Gold Standard	78124NY0940004	592.79	1,185.57	1,007.74	1,689.43	NA
Univera Silver Standard	78124NY0940010	513.45	1,026.89	872.86	1,463.32	NA
Univera Gold Select	78124NY0940016	594.22	1,188.44	1,010.17	1,693.52	NA
Univera Bronze Standard	78124NY0950004	403.05	806.09	685.19	1,148.68	NA
Univera Silver Select	78124NY0950010	474.40	948.79	806.48	1,352.04	NA
Univera Bronze Select	78124NY0950014	379.01	758.01	644.31	1,080.17	NA
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Univera Platinum Standard	78124NY0930002	696.78	1,393.57	1,184.52	1,985.83	NA
Univera Platinum Select	78124NY0930008	697.72	1,395.45	1,186.12	1,988.51	NA
Univera Gold Standard	78124NY0940002	604.05	1,208.10	1,026.88	1,721.53	NA
Univera Silver Standard	78124NY0940008	523.20	1,046.40	889.45	1,491.13	NA
Univera Gold Select	78124NY0940014	605.51	1,211.02	1,029.37	1,725.70	NA
Univera Bronze Standard	78124NY0950002	410.70	821.41	698.20	1,170.50	NA
Univera Silver Select	78124NY0950008	483.42	966.82	821.80	1,377.73	NA
Univera Bronze Select	78124NY0950012	386.20	772.42	656.55	1,100.69	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental]</u></b>						
Univera Platinum Standard	78124NY0930003	690.69	1,381.38	1,174.17	1,968.48	NA
Univera Platinum Select	78124NY0930009	690.90	1,381.79	1,174.52	1,969.06	NA
Univera Gold Standard	78124NY0940003	599.09	1,198.18	1,018.44	1,707.40	NA
Univera Silver Standard	78124NY0940009	519.45	1,038.88	883.07	1,480.41	NA
Univera Gold Select	78124NY0940015	600.41	1,200.81	1,020.69	1,711.15	NA
Univera Bronze Standard	78124NY0950003	406.95	813.89	691.81	1,159.78	NA
Univera Silver Select	78124NY0950009	480.59	961.16	816.99	1,369.67	NA
Univera Bronze Select	78124NY0950013	385.19	770.38	654.83	1,097.80	NA
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Univera Platinum Standard	78124NY0930001	703.81	1,407.62	1,196.47	2,005.88	NA
Univera Platinum Select	78124NY0930007	704.02	1,408.04	1,196.84	2,006.47	NA
Univera Gold Standard	78124NY0940001	610.47	1,220.94	1,037.80	1,739.84	NA
Univera Silver Standard	78124NY0940007	529.32	1,058.62	899.85	1,508.53	NA
Univera Gold Select	78124NY0940013	611.81	1,223.63	1,040.08	1,743.65	NA
Univera Bronze Standard	78124NY0950001	414.68	829.35	704.95	1,181.82	NA
Univera Silver Select	78124NY0950007	489.72	979.42	832.51	1,395.69	NA
Univera Bronze Select	78124NY0950011	392.51	785.01	667.27	1,118.66	NA
<b><u>EXEC-2 (Rev.1)[no Pediatric Dental]</u></b>						
Univera Platinum Standard	78124NY0930006	NA	NA	NA	NA	281.72
Univera Gold Standard	78124NY0940006	NA	NA	NA	NA	244.22
Univera Silver Standard	78124NY0940012	NA	NA	NA	NA	211.54
Univera Bronze Standard	78124NY0950006	NA	NA	NA	NA	166.06
<b><u>EXEC-2 (Rev.1)[with Pediatric Dental]</u></b>						
Univera Platinum Standard	78124NY0930005	NA	NA	NA	NA	284.57
Univera Gold Standard	78124NY0940005	NA	NA	NA	NA	246.83
Univera Silver Standard	78124NY0940011	NA	NA	NA	NA	214.02
Univera Bronze Standard	78124NY0950005	NA	NA	NA	NA	167.66
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental]</u></b>						
Univera Preferred Gold	78124NY1140004	582.34	1,164.69	989.98	1,659.68	NA
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>						
Univera Preferred Gold	78124NY1140002	593.40	1,186.82	1,008.79	1,691.21	NA
<b><u>EXEC-4 (Rev.1)[with Pediatric Dental]</u></b>						
Univera Preferred Gold	78124NY1140003	588.52	1,177.05	1,000.49	1,677.30	NA

**Excellus Health Plan, Inc.**

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2015

Community Rated

**2015 Individual Premium Rates - Buffalo Region**

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<b><u>EXEC-4 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b> Univera Preferred Gold	78124NY1140001	599.70	1,199.41	1,019.50	1,709.17	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b> Univera IND Platinum Standard IND PPO	78124NY1100004	689.68	1,379.35	1,172.45	1,965.58	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b> Univera IND Platinum Standard IND PPO	78124NY1100002	702.79	1,405.56	1,194.73	2,002.93	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b> Univera IND Platinum Standard IND PPO	78124NY1100003	696.58	1,393.15	1,184.18	1,985.26	NA
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b> Univera IND Platinum Standard IND PPO	78124NY1100001	709.81	1,419.62	1,206.67	2,022.98	NA
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b> Univera IND Platinum Standard IND PPO	78124NY1100006	NA	NA	NA	NA	284.15
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b> Univera IND Platinum Standard IND PPO	78124NY1100005	NA	NA	NA	NA	287.00

**Outline of Benefits**

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Off Exchange - All Regions**

Option	HIOS ID	Plan Design	Single Ded.	Coins. IN	PCP Copay	SPC Copay	Single OOP Max	Rx	Dependent Coverage
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS Platinum Standard	78124NY0880004	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
Excellus BCBS Platinum Select	78124NY0880010	Copay	0	0%	15	25	6350	\$5/\$25/\$50	To age 26
Excellus BCBS Gold Standard	78124NY0890004	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	To age 26
Excellus BCBS Silver Standard	78124NY0890010	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	To age 26
Excellus BCBS Gold Select	78124NY0890016	Hybrid	600	n/a	25	40	4000	\$5/\$35/\$70	To age 26
Excellus BCBS Bronze Standard	78124NY0900004	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	To age 26
Excellus BCBS Silver Select	78124NY0900010	HDHP/HSA	2000	20%	ded/coins	ded/coins	5000	\$10/\$45/\$90	To age 26
Excellus BCBS Bronze Select	78124NY0900014	HDHP/HSA	4500	50%	ded/coins	ded/coins	6350	\$10/40%/50%	To age 26
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS Platinum Standard	78124NY0880002	Copay	0	0%	15	35	2000	\$10/\$30/\$60	Through age 29
Excellus BCBS Platinum Select	78124NY0880008	Copay	0	0%	15	25	6350	\$5/\$25/\$50	Through age 29
Excellus BCBS Gold Standard	78124NY0890002	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	Through age 29
Excellus BCBS Silver Standard	78124NY0890008	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	Through age 29
Excellus BCBS Gold Select	78124NY0890014	Hybrid	600	n/a	25	40	4000	\$5/\$35/\$70	Through age 29
Excellus BCBS Bronze Standard	78124NY0900002	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	Through age 29
Excellus BCBS Silver Select	78124NY0900008	HDHP/HSA	2000	20%	ded/coins	ded/coins	5000	\$10/\$45/\$90	Through age 29
Excellus BCBS Bronze Select	78124NY0900012	HDHP/HSA	4500	50%	ded/coins	ded/coins	6350	\$10/40%/50%	Through age 29
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS Platinum Standard	78124NY0880003	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
Excellus BCBS Platinum Select	78124NY0880009	Copay	0	0%	15	25	6350	\$5/\$25/\$50	To age 26
Excellus BCBS Gold Standard	78124NY0890003	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	To age 26
Excellus BCBS Silver Standard	78124NY0890009	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	To age 26
Excellus BCBS Gold Select	78124NY0890015	Hybrid	600	n/a	25	40	4000	\$5/\$35/\$70	To age 26
Excellus BCBS Bronze Standard	78124NY0900003	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	To age 26
Excellus BCBS Silver Select	78124NY0900009	HDHP/HSA	2000	20%	ded/coins	ded/coins	5000	\$10/\$45/\$90	To age 26
Excellus BCBS Bronze Select	78124NY0900013	HDHP/HSA	4500	50%	ded/coins	ded/coins	6350	\$10/40%/50%	To age 26
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS Platinum Standard	78124NY0880001	Copay	0	0%	15	35	2000	\$10/\$30/\$60	Through age 29
Excellus BCBS Platinum Select	78124NY0880007	Copay	0	0%	15	25	6350	\$5/\$25/\$50	Through age 29
Excellus BCBS Gold Standard	78124NY0890001	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	Through age 29
Excellus BCBS Silver Standard	78124NY0890007	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	Through age 29
Excellus BCBS Gold Select	78124NY0890013	Hybrid	600	n/a	25	40	4000	\$5/\$35/\$70	Through age 29
Excellus BCBS Bronze Standard	78124NY0900001	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	Through age 29
Excellus BCBS Silver Select	78124NY0900007	HDHP/HSA	2000	20%	ded/coins	ded/coins	5000	\$10/\$45/\$90	Through age 29
Excellus BCBS Bronze Select	78124NY0900011	HDHP/HSA	4500	50%	ded/coins	ded/coins	6350	\$10/40%/50%	Through age 29
<b><u>EXEC-2 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS Platinum Standard	78124NY0880006	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
Excellus BCBS Gold Standard	78124NY0890006	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	To age 26
Excellus BCBS Silver Standard	78124NY0890012	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	To age 26
Excellus BCBS Bronze Standard	78124NY0900006	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	To age 26
<b><u>EXEC-2 (Rev.1)[with Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS Platinum Standard	78124NY0880005	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
Excellus BCBS Gold Standard	78124NY0890005	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	To age 26
Excellus BCBS Silver Standard	78124NY0890011	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	To age 26
Excellus BCBS Bronze Standard	78124NY0900005	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	To age 26
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS Bassett Preferred Gold	78124NY0920004	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	To age 26
Excellus BCBS Bassett Preferred Silver	78124NY0920008	Hybrid	1250	0%	30	50	6350	\$10/\$35/\$70	To age 26
Excellus BCBS CNY Preferred Gold	78124NY1130004	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	To age 26

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Off Exchange - All Regions**

Option	HIOS ID	Plan Design	Single Ded.	Coins. IN	PCP Copay	SPC Copay	Single OOP Max	Rx	Dependent Coverage
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS Bassett Preferred Gold	78124NY0920002	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	Through age 29
Excellus BCBS Bassett Preferred Silver	78124NY0920006	Hybrid	1250	0%	30	50	6350	\$10/\$35/\$70	Through age 29
Excellus BCBS CNY Preferred Gold	78124NY1130002	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	Through age 29
<b><u>EXEC-4 (Rev.1)[with Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS Bassett Preferred Gold	78124NY0920003	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	To age 26
Excellus BCBS Bassett Preferred Silver	78124NY0920007	Hybrid	1250	0%	30	50	6350	\$10/\$35/\$70	To age 26
Excellus BCBS CNY Preferred Gold	78124NY1130003	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	To age 26
<b><u>EXEC-4 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS Bassett Preferred Gold	78124NY0920001	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	Through age 29
Excellus BCBS Bassett Preferred Silver	78124NY0920005	Hybrid	1250	0%	30	50	6350	\$10/\$35/\$70	Through age 29
Excellus BCBS CNY Preferred Gold	78124NY1130001	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	Through age 29
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Preferred Provider Organization Contract</b>									
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090004	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Preferred Provider Organization Contract</b>									
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090002	Copay	0	0%	15	35	2000	\$10/\$30/\$60	Through age 29
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090003	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090001	Copay	0	0%	15	35	2000	\$10/\$30/\$60	Through age 29
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090006	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS IND Platinum Standard IND PPO	78124NY1090005	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26

**Excellus Health Plan, Inc.**  
Univera Healthcare

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Off Exchange - Buffalo Region**

Option	HIOS ID	Plan Design	Single Ded.	Coins. IN	PCP Copay	SPC Copay	Single OOP Max	Rx	Dependent Coverage
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera Platinum Standard	78124NY0930004	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
Univera Platinum Select	78124NY0930010	Copay	0	0%	15	25	6350	\$5/\$25/\$50	To age 26
Univera Gold Standard	78124NY0940004	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	To age 26
Univera Silver Standard	78124NY0940010	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	To age 26
Univera Gold Select	78124NY0940016	Hybrid	600	n/a	25	40	4000	\$5/\$35/\$70	To age 26
Univera Bronze Standard	78124NY0950004	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	To age 26
Univera Silver Select	78124NY0950010	HDHP/HSA	2000	20%	ded/coins	ded/coins	5000	\$10/\$45/\$90	To age 26
Univera Bronze Select	78124NY0950014	HDHP/HSA	4500	50%	ded/coins	ded/coins	6350	\$10/40%/50%	To age 26
<b><u>EXEC-1 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera Platinum Standard	78124NY0930002	Copay	0	0%	15	35	2000	\$10/\$30/\$60	Through age 29
Univera Platinum Select	78124NY0930008	Copay	0	0%	15	25	6350	\$5/\$25/\$50	Through age 29
Univera Gold Standard	78124NY0940002	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	Through age 29
Univera Silver Standard	78124NY0940008	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	Through age 29
Univera Gold Select	78124NY0940014	Hybrid	600	n/a	25	40	4000	\$5/\$35/\$70	Through age 29
Univera Bronze Standard	78124NY0950002	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	Through age 29
Univera Silver Select	78124NY0950008	HDHP/HSA	2000	20%	ded/coins	ded/coins	5000	\$10/\$45/\$90	Through age 29
Univera Bronze Select	78124NY0950012	HDHP/HSA	4500	50%	ded/coins	ded/coins	6350	\$10/40%/50%	Through age 29
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera Platinum Standard	78124NY0930003	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
Univera Platinum Select	78124NY0930009	Copay	0	0%	15	25	6350	\$5/\$25/\$50	To age 26
Univera Gold Standard	78124NY0940003	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	To age 26
Univera Silver Standard	78124NY0940009	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	To age 26
Univera Gold Select	78124NY0940015	Hybrid	600	n/a	25	40	4000	\$5/\$35/\$70	To age 26
Univera Bronze Standard	78124NY0950003	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	To age 26
Univera Silver Select	78124NY0950009	HDHP/HSA	2000	20%	ded/coins	ded/coins	5000	\$10/\$45/\$90	To age 26
Univera Bronze Select	78124NY0950013	HDHP/HSA	4500	50%	ded/coins	ded/coins	6350	\$10/40%/50%	To age 26
<b><u>EXEC-1 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera Platinum Standard	78124NY0930001	Copay	0	0%	15	35	2000	\$10/\$30/\$60	Through age 29
Univera Platinum Select	78124NY0930007	Copay	0	0%	15	25	6350	\$5/\$25/\$50	Through age 29
Univera Gold Standard	78124NY0940001	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	Through age 29
Univera Silver Standard	78124NY0940007	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	Through age 29
Univera Gold Select	78124NY0940013	Hybrid	600	n/a	25	40	4000	\$5/\$35/\$70	Through age 29
Univera Bronze Standard	78124NY0950001	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	Through age 29
Univera Silver Select	78124NY0950007	HDHP/HSA	2000	20%	ded/coins	ded/coins	5000	\$10/\$45/\$90	Through age 29
Univera Bronze Select	78124NY0950011	HDHP/HSA	4500	50%	ded/coins	ded/coins	6350	\$10/40%/50%	Through age 29
<b><u>EXEC-2 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera Platinum Standard	78124NY0930006	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
Univera Gold Standard	78124NY0940006	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	To age 26
Univera Silver Standard	78124NY0940012	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	To age 26
Univera Bronze Standard	78124NY0950006	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	To age 26
<b><u>EXEC-2 (Rev.1)[with Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera Platinum Standard	78124NY0930005	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
Univera Gold Standard	78124NY0940005	Hybrid	600	0%	25	40	4000	\$10/\$35/\$70	To age 26
Univera Silver Standard	78124NY0940011	Hybrid	2000	0%	30	50	5500	\$10/\$35/\$70	To age 26
Univera Bronze Standard	78124NY0950005	HDHP/HSA	3000	50%	ded/coins	ded/coins	6350	\$10/\$35/\$70	To age 26

**Excellus Health Plan, Inc.**  
Univera Healthcare

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Off Exchange - Buffalo Region**

Option	HIOS ID	Plan Design	Single Ded.	Coins. IN	PCP Copay	SPC Copay	Single OOP Max	Rx	Dependent Coverage
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera Preferred Gold	78124NY1140004	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	To age 26
<b><u>EXEC-4 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera Preferred Gold	78124NY1140002	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	Through age 29
<b><u>EXEC-4 (Rev.1)[with Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera Preferred Gold	78124NY1140003	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	To age 26
<b><u>EXEC-4 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera Preferred Gold	78124NY1140001	Hybrid	400	0%	25	40	4000	\$5/\$35/\$70	Through age 29
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera IND Platinum Standard IND PPO	78124NY1100004	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera IND Platinum Standard IND PPO	78124NY1100002	Copay	0	0%	15	35	2000	\$10/\$30/\$60	Through age 29
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b>									
<b>Preferred Provider Organization Contract</b>									
Univera IND Platinum Standard IND PPO	78124NY1100003	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
<b><u>EXEC-1 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental],EXER-1 (Rev.1)</u></b>									
<b>Preferred Provider Organization Contract</b>									
Univera IND Platinum Standard IND PPO	78124NY1100001	Copay	0	0%	15	35	2000	\$10/\$30/\$60	Through age 29
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera IND Platinum Standard IND PPO	78124NY1100006	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26
<b><u>EXEC-2 (Rev.1), EXER-2 (Rev.1)[with Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera IND Platinum Standard IND PPO	78124NY1100005	Copay	0	0%	15	35	2000	\$10/\$30/\$60	To age 26

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**  
**EXEC-1 (Rev.1) (Exclusive Provider Organization);**  
**EXEC-2 (Rev.1) (Exclusive Provider Organization Child Only);**  
**EXER-2 (Rev.1) (Out of Network Rider)**  
Platinum, Gold, & Silver  
NYS Benchmark Plan

Individual		
Benefit Type	In-Network	Out-of-Network
<b>PROVIDER NETWORK &amp; SERVICE AREA</b>		
Provider Network Counties - BCBS	BCBS 31 counties only	
Provider Network Counties - Univera	39 Counties: BCBS 31 plus Univera 8	
BCBS Service Area	Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson	
Univera Service Area	Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Niagara; Orleans; Wyoming.	
<b>WHO IS COVERED</b>		
Type of Tiers – 4 Tier	Single - Subscriber or Child only 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family	
Dependent Coverage Federal Mandate	26 to end of month of birthday	
Dependents through age 29 State Mandate	Dependent Make Available	
Domestic Partner Coverage	Covered - standard	
<b>COST SHARING EXPENSES</b>		
Contract Year	Calendar Year	
Deductible · Single/ Family	Single: Platinum: \$[0] Gold: \$[600] Silver: \$[2,000] Silver CSR: \$[0; 250; 1,200] Family = 2X single	Not Covered
4th Quarter Deductible Carry-Over Y/N	No	No
Copayment	Platinum: \$[15] PCP/ \$[35] SPC Gold: \$[25] PCP/ \$[40] SPC Silver: \$[30] PCP/ \$[50] SPC Silver CSR: \$[10 PCP/20 SPC; 15 PCP/35 SPC; 30 PCP/50 SPC]	Not Covered
Coinsurance	Platinum, Gold, Silver, Silver CSR: None	Not Covered
Annual Out-of-Pocket Maximum	Single: Platinum: \$[2,000] Gold: \$[4,000] Silver: \$[5,500] Silver CSR: \$[1,000; 2,000; 5,200] Family = 2X single	Not Covered
Annual Benefit Maximum Federal Mandate	None	
Lifetime Benefit Maximum Federal Mandate	None	
<b>HOSPITAL INPATIENT SERVICES</b>		
Inpatient Hospital Services NYS & Federal Essential Health Benefit	Platinum: \$[500] copay per admission Gold: \$[1,000] copay per admission Silver: \$[1,500] copay per admission Silver CSR: \$[100; 250; 1,500] copay per admission	Not Covered
Mental Health Care Includes Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Substance Use Detoxification, Rehabilitation & Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Skilled Nursing Facility NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 200 days per contract year	Not Covered
Physical Rehabilitation includes habilitative services NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 1 consecutive 60 day stay per condition per lifetime	Not Covered

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**  
**EXEC-1 (Rev.1) (Exclusive Provider Organization);**  
**EXEC-2 (Rev.1) (Exclusive Provider Organization Child Only);**  
**EXER-2 (Rev.1) (Out of Network Rider)**  
**Platinum, Gold, & Silver**  
**NYS Benchmark Plan**

<b>Individual</b>		
<b>Benefit Type</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Maternity Care</b> NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies.	Not Covered
<b>Maternity Care – Routine Newborn Nursery</b> NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	Not Covered
<b>Implanted Devices</b> NYS & Federal Essential Health Benefit	Covered in Full	Not Covered
<b>End of Life Care</b> State Mandate NYS Essential Health Benefit	Inpatient Hospital cost share applies.	Not Covered
<b>Observation Stay</b> NYS & Federal Essential Health Benefit	Platinum: \$[100] copay Gold: \$[150] Silver: \$[150] Silver CSR: \$[50; 75; 150]	Not Covered
<b>HOME CARE</b> NYS & Federal Essential Health Benefit	Deduct/ PCP Copay 40 visits per contract year	Not Covered
<b>HOSPICE CARE</b> NYS & Federal Essential Health Benefit	Inpatient: Inpatient Hospital cost share applies. Hospice facility or Home: Deduct/ PCP copay per visit 210 days per year, 5 family bereavement visits	Not Covered
<b>HOSPITAL OUTPATIENT SERVICES</b>		
<b>Surgical Care including Surgicenters &amp; Freestanding Facilities</b> NYS & Federal Essential Health Benefit	Platinum: Deduct/ \$[100] copay Gold: Deduct/ \$[100] Silver: Deduct/ \$[100] Silver CSR: Deduct/ \$[25; 75; 100]	Not Covered
<b>Pre-admission/Pre-Operative Testing</b> NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	Not Covered
<b>Diagnostic &amp; Routine X-ray</b> NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Not Covered
<b>Advanced Imaging Services</b> NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
<b>Diagnostic &amp; Routine Laboratory and Pathology</b> NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
<b>Advanced Imaging Services</b> NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Not Covered
<b>Diagnostic &amp; Routine Laboratory and Pathology</b> NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Not Covered
<b>Radiation Therapy</b> NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit	Not Covered
<b>Chemotherapy</b> NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit	Not Covered
<b>Infusion Therapy</b> NYS Essential Health Benefit	Deduct/ PCP Copay per visit	Not Covered
<b>Dialysis (all forms)</b> NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit	Not covered except Out of Area only: Deduct/ PCP Copay per visit
<b>Mental Health Care</b> NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit Unlimited visits	Not Covered
<b>Autism Applied Behavior Analysis</b> State Mandate NYS Essential Health Benefit	Deduct/ PCP Copay per visit Limit of 680 hours per contract year	Not Covered
<b>Substance Use Services</b> NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit Unlimited visits. Covers 20 visits per calendar year for family therapy.	Not Covered
<b>Covered Therapies - Rehabilitation</b> <b>Only Physical, Speech, and Occupational Therapy</b> NYS & Federal Essential Health Benefit	Platinum: \$[25] copay per visit Gold: \$[30] Silver: \$[30] Silver CSR: \$[15; 25; 30]	Not Covered

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**  
**EXEC-1 (Rev.1) (Exclusive Provider Organization);**  
**EXEC-2 (Rev.1) (Exclusive Provider Organization Child Only);**  
**EXER-2 (Rev.1) (Out of Network Rider)**  
Platinum, Gold, & Silver  
NYS Benchmark Plan

Individual		
Benefit Type	In-Network	Out-of-Network
<b>Covered Therapies - Habilitation</b> <b>Only Physical, Speech, and Occupational Therapy</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Platinum: \$[25] copay per visit Gold: \$[30] Silver: \$[30] Silver CSR: \$[15; 25; 30] 60 visits per condition per lifetime	Not Covered
<b>Pulmonary Rehabilitation</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP Copay per visit	Not Covered
<b>Cardiac Rehabilitation</b> <b>NYS &amp; Federal Essential Health Benefit</b>	PCP Copay	Not Covered
<b>PHYSICIAN SERVICES</b>		
<b>Inpatient Hospital Surgery</b> <b>NYS Essential Health Benefit</b>	Platinum: \$[100] copay Gold: Deduct/ \$[100] Silver: Deduct/ \$[100] Silver CSR: Deduct/ \$[25; 75; 100]	Not Covered
<b>Outpatient Hospital &amp; Ambulatory Surgery</b> <b>NYS Essential Health Benefit</b>	Platinum: \$[100] copay Gold: Deduct/ \$[100] Silver: Deduct/ \$[100] Silver CSR: Deduct/ \$[25; 75; 100]	Not Covered
<b>Office Surgery</b> <b>NYS Essential Health Benefit</b>	Deduct/ PCP/Specialist	Not Covered
<b>Anesthesia</b> <b>Includes IP, OP, OV and maternity</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Covered in Full, no Deductible	Not Covered
<b>Covered Therapies - Rehabilitation</b> <b>Only Physical, Speech, and Occupational Therapy</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Platinum: \$[25] copay per visit Gold: Deduct/ \$[30] Silver: Deduct/ \$[30] Silver CSR: Deduct/ \$[15; 25; 30] 60 visits per condition per lifetime	Not Covered
<b>Covered Therapies - Habilitation</b> <b>Only Physical, Speech, and Occupational Therapy</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Platinum: \$[25] copay per visit Gold: Deduct/ \$[30] Silver: Deduct/ \$[30] Silver CSR: Deduct/ \$[15; 25; 30] 60 visits per condition per lifetime	Not Covered
<b>Pulmonary Rehabilitation</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP Copay	Not Covered
<b>Cardiac Rehabilitation</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP Copay	Not Covered
<b>Additional Surgical Opinion</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Second Medical Opinion for Cancer</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Maternity Care: Normal, Complications &amp; Termination.</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Platinum: \$[100] copay Gold: Deduct/ \$[100] Silver: Deduct/ \$[100] Silver CSR: Deduct/ \$[25; 75; 100]	Not Covered
<b>Prenatal Care</b> <b>HCR Preventive Service</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Covered in full	Not Covered
<b>In-Hospital Physician Visits</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Deduct/ \$0 Copay	Not Covered
<b>PHYSICIAN OFFICE - OTHER SERVICES</b>		
<b>Diagnostic &amp; Routine Laboratory and Pathology</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Not Covered
<b>Diagnostic &amp; Routine X-ray</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Not Covered
<b>Advanced Imaging Services</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Radiation Therapy</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay	Not Covered
<b>Chemotherapy</b> <b>NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay	Not Covered

**Excellus Health Plan, Inc.**  
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Platinum, Gold, & Silver  
NYS Benchmark Plan

Individual		
Benefit Type	In-Network	Out-of-Network
Infusion Therapy NYS Essential Health Benefit	Deduct/ PCP copay	Not Covered
Dialysis (all forms) NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not covered except Out of Area only: Deduct/ PCP Copay per visit
Mental Health Care NYS & Federal Essential Health Benefit	Deduct/ PCP copay Unlimited visits	Not Covered
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	Deduct/ PCP copay Limit of 680 hours per contract year	Not Covered
Substance Use Services NYS & Federal Essential Health Benefit	Deduct/ PCP copay Excludes family therapy.	Not Covered
Office Visits - Diagnostic NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered
Medications Administered in Office NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered
Eye Exams - Diagnostic NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered
Hearing Evaluations Diagnostic NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered
Chiropractic Care NYS & Federal Essential Health Benefit	Deduct/ Specialist copay	Not Covered
Office & Outpatient Consultations NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered
Allergy Testing NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered
Allergy Treatment Includes Serum and Injections NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered
Hearing Evaluations Routine NYS Essential Health Benefit	Deduct/ Specialist copay	Not Covered
Hearing Aids NYS & Federal Essential Health Benefit	Platinum: [10]% Coins Gold: Deduct/ [20]% Coins Silver: Deduct/ [30]% Coins Silver CSR: Deduct/ [5; 10; 25]% Coins Single purchase once every 3 years	Not Covered
Cochlear Implants	Platinum: [10]% Coins Gold: Deduct/ [20]% Coins Silver: Deduct/ [30]% Coins Silver CSR: Deduct/ [5; 10; 25]% Coins One Per Ear Per Time Covered	Not Covered
<b>PREVENTIVE SERVICES</b>		
<b>Outpatient Facility &amp; Professional Provider</b>		
Adult Physical Examinations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Not Covered
Adult Immunizations Federal HCR Preventive Service NYS Essential Health Benefit Federal Essential Health Benefit	Covered in full	Not Covered
Well Child Visits and Immunizations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Routine Gynecological Exams Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Cervical Cytology Preventive only Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Prostate Cancer Screenings Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered

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**NYS Benchmark Plan**

Individual		
Benefit Type	In-Network	Out-of-Network
<b>Mammogram Screening</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Not Covered
<b>Bone Density Testing</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Not Covered
<b>Colonoscopy Screening</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Not Covered
<b>Family Planning</b> HCR Preventive Service	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Not Covered
<b>ADDITIONAL BENEFITS</b>		
<b>Treatment of Diabetes Insulin &amp; Supplies</b> NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered
<b>Diabetic Education</b> NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered
<b>Diabetic Equipment</b> NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered
<b>Autism Assistive Communication Devices (ACD)</b> State Mandate NYS Essential Health Benefit	Deduct/ PCP copay	Not Covered
<b>Autologous Blood Banking</b> NYS Essential Health Benefit	Platinum: [10]% Coins Gold: Deduct/ [20]% Coins Silver: Deduct/ [30]% Coins Silver CSR: Deduct/ [5; 10; 25]% Coins	Not Covered
<b>Durable Medical Equipment (DME)</b> NYS & Federal Essential Health Benefit	Platinum: [10]% Coins Gold: Deduct/ [20]% Coins Silver: Deduct/ [30]% Coins Silver CSR: Deduct/ [5; 10; 25]% Coins	Not Covered
<b>External Prosthetics</b> NYS & Federal Essential Health Benefit	Platinum: [10]% Coins Gold: Deduct/ [20]% Coins Silver: Deduct/ [30]% Coins Silver CSR: Deduct/ [5; 10; 25]% Coins 1 external prosthetic device per limb per lifetime	Not Covered
<b>Orthotics</b> Foot orthotics included	Not Covered	Not Covered
<b>Medical Supplies</b> NYS & Federal Essential Health Benefit	Platinum: [10]% Coins Gold: Deduct/ [20]% Coins Silver: Deduct/ [30]% Coins Silver CSR: Deduct/ [5; 10; 25]% Coins	Not Covered
<b>HEALTH &amp; WELLNESS</b> <b>Incentive Programs</b> NYS & Federal Essential Health Benefit	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months
<b>EMERGENCY SERVICES</b>		
<b>Emergency Condition</b>		
<b>Facility – Emergency Room</b> NYS & Federal Essential Health Benefit	Platinum: \$[100] copay Gold: Deduct/ \$[150] Silver: Deduct/ \$[150] Silver CSR: Deduct/ \$[50; 75; 150]	Platinum: \$[100] copay Gold: Deduct/ \$[150] Silver: Deduct/ \$[150] Silver CSR: Deduct/ \$[50; 75; 150]
<b>Physician’s Hospital Emergency Room Visit</b> NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	Deduct/ \$0 Copay
<b>Prehospital Emergency Services/Transportation</b> NYS & Federal Essential Health Benefit	Platinum: \$[100] copay Gold: Deduct/ \$[150] Silver: Deduct/ \$[150] Silver CSR: Deduct/ \$[50; 75; 150]	Platinum: \$[100] copay Gold: Deduct/ \$[150] Silver: Deduct/ \$[150] Silver CSR: Deduct/ \$[50; 75; 150]
<b>Freestanding Urgent Care Center</b> Art 28 Facility NYS & Federal Essential Health Benefit	Platinum: \$55 copay Gold: Deduct/ \$60 copay Silver: Deduct/ \$70 copay Silver CSR: Deduct/ \$[30; 50; 70] copay	Not Covered

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NYS Benchmark Plan

Individual		
Benefit Type	In-Network	Out-of-Network
Physician's Freestanding Urgent Care Center (Art 28 Facility) NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	Not Covered
Physician Urgent Care Office Visit NYS & Federal Essential Health Benefit	See office visit benefit	Not Covered
<b>VISION BENEFITS</b>		
Eye Exams Routine - Adults	Not Covered	Not Covered
Eyewear - Adults	Not Covered	Not Covered
Eye Exams Routine - Pediatric NYS & Federal Essential Health Benefit	Deduct/ PCP Copay 1 per 12 month period	Not Covered
Eyewear - Pediatric NYS & Federal Essential Health Benefit	Platinum: [10]% Coins Gold: Deduct/ [20]% Coins Silver: Deduct/ [30]% Coins Silver CSR: Deduct/ [5; 10; 25]% Coins Lenses or Contacts once in any 12 month period Frames once in any 12 month period	Not Covered
<b>DENTAL BENEFITS</b>		
Adult Dental	Not Covered	Not Covered
Pediatric Dental - Emergency Care NYS & Federal Essential Health Benefit	Deduct/ PCP Copay	Not Covered
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	Deduct/ PCP Copay	Not Covered
Preventive - Topical Fluoride Application	Preventive cost share 1 per six months	Preventive cost share 1 per six months
Preventive - Sealants	Preventive cost share	Preventive cost share
Preventive - Space Maintainers	Preventive cost share	Preventive cost share
Pediatric Dental - Routine NYS & Federal Essential Health Benefit	Deduct/ PCP Copay	Not Covered
Pediatric Dental - Endodontic NYS & Federal Essential Health Benefit	Deduct/ PCP Copay	Not Covered
Pediatric Dental - Prosthodontics NYS & Federal Essential Health Benefit	Deduct/ PCP Copay	Not Covered
Pediatric Dental - Orthodontics NYS & Federal Essential Health Benefit	Deduct/ PCP Copay	Not Covered
<b>PRESCRIPTION DRUGS</b>		
<b>Closed Formulary</b>		
Generic or Tier 1/Tier 2/Tier 3 NYS & Federal Essential Health Benefit	Retail: 1 copay per 30 day supply Mail Order: Mail Order copay is 2.5 times retail for a 90 day supply	
Platinum	Copay: \$10 /\$30/\$60	Not Covered
Gold	Copay: \$10 /\$35/\$70	Not Covered
Silver	Copay: \$10 /\$35/\$70	Not Covered
Silver 200-250 FPL	Copay: \$10 /\$35/\$70	Not Covered
Silver 150-200 FPL	Copay: \$9 /\$20/\$40	Not Covered
Silver 100-150 FPL	Copay: \$6/\$15/\$30	Not Covered
Native American 300 FPL	\$0 all tiers	Not Covered
Bronze	Deductible Copay: \$10 /\$35/\$70	Not Covered
<b>WAITING PERIODS</b>	None	
<b>EXCLUSIONS</b>	Standard Exclusions apply	

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Individual

Benefit Type	In-Network	Out-of-Network
<b>PROVIDER NETWORK &amp; SERVICE AREA</b>		
Provider Network Counties - BCBS	BCBS 31 counties only	
Provider Network Counties - Univera	39 Counties: BCBS 31 plus Univera 8	
BCBS Service Area	Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson	
Univera Service Area	Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Niagara; Orleans; Wyoming.	
<b>WHO IS COVERED</b>		
Type of Tiers – 4 Tier	Single - Subscriber or Child only 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family	
Dependent Coverage Federal Mandate	26 to end of month of birthday	
Dependents through age 29 State Mandate	Dependent Make Available	
Domestic Partner Coverage	Covered - standard	
<b>COST SHARING EXPENSES</b>		
Contract Year	Calendar Year	
Deductible · Single/ Family	Single: Bronze: \$3,000 Family = 2X single	Not Covered
4th Quarter Deductible Carry-Over Y/N	No	No
Copayment	Bronze: None	Not Covered
Coinsurance	Bronze: [50]%	Not Covered
Annual Out-of-Pocket Maximum	Single: Bronze: \$[6,350] Family = 2X single	Not Covered
Annual Benefit Maximum Federal Mandate	None	
Lifetime Benefit Maximum Federal Mandate	None	
<b>HOSPITAL INPATIENT SERVICES</b>		
Inpatient Hospital Services NYS & Federal Essential Health Benefit	Deduct/Coins Unlimited days	Not Covered
Mental Health Care Includes Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Substance Use Detoxification, Rehabilitation & Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Skilled Nursing Facility NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 200 days per contract year	Not Covered
Physical Rehabilitation includes habilitative services NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 1 consecutive 60 day stay per condition per lifetime	Not Covered
Maternity Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies.	Not Covered
Maternity Care – Routine Newborn Nursery NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Implanted Devices NYS & Federal Essential Health Benefit	Covered in Full	Not Covered
End of Life Care State Mandate NYS Essential Health Benefit	Inpatient Hospital cost share applies.	Not Covered
Observation Stay NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered

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Individual

Benefit Type	In-Network	Out-of-Network
HOME CARE NYS & Federal Essential Health Benefit	<b>Bronze:</b> Deduct/Coins <b>Catastrophic:</b> Deduct/Coins	Not Covered
HOSPICE CARE NYS & Federal Essential Health Benefit	Inpatient: Inpatient Hospital cost share applies. Hospice facility or Home: Deduct/Coins 210 days per year, 5 family bereavement visits	Not Covered
<b>HOSPITAL OUTPATIENT SERVICES</b>		
Surgical Care including Surgicenters & Freestanding Facilities NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Pre-admission/Pre-Operative Testing NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Diagnostic & Routine X-ray NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Advanced Imaging Services NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Advanced Imaging Services NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Radiation Therapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Chemotherapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Infusion Therapy NYS Essential Health Benefit	Deduct/Coins	Not Covered
Dialysis (all forms) NYS & Federal Essential Health Benefit	Deduct/Coins	Not covered except Out of Area only: Deduct/ PCP Copay per visit
Mental Health Care NYS & Federal Essential Health Benefit	Deduct/Coins Unlimited visits	Not Covered
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	Deduct/Coins Limit of 680 hours per contract year	Not Covered
Substance Use Services NYS & Federal Essential Health Benefit	Deduct/Coins Unlimited visits. Covers 20 visits per calendar year for family therapy.	Not Covered
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Pulmonary Rehabilitation NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Cardiac Rehabilitation NYS & Federal Essential Health Benefit	PCP Copay	Not Covered
<b>PHYSICIAN SERVICES</b>		
Inpatient Hospital Surgery NYS Essential Health Benefit	Deduct/Coins	Not Covered
Outpatient Hospital & Ambulatory Surgery NYS Essential Health Benefit	Deduct/Coins	Not Covered
Office Surgery NYS Essential Health Benefit	Deduct/Coins	Not Covered

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Individual

Benefit Type	In-Network	Out-of-Network
Anesthesia Includes IP, OP, OV and maternity NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Coins 60 visits per condition per lifetime	Not Covered
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Coins 60 visits per condition per lifetime	Not Covered
Pulmonary Rehabilitation NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Cardiac Rehabilitation NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Additional Surgical Opinion NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Second Medical Opinion for Cancer NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Maternity Care: Normal, Complications & Termination. NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Prenatal Care HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
In-Hospital Physician Visits NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>PHYSICIAN OFFICE - OTHER SERVICES</b>		
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Diagnostic & Routine X-ray NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Advanced Imaging Services NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Radiation Therapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Chemotherapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Infusion Therapy NYS Essential Health Benefit	Deduct/Coins	Not Covered
Dialysis (all forms) NYS & Federal Essential Health Benefit	Deduct/Coins	Not covered except Out of Area only: Deduct/ PCP Copay per visit
Mental Health Care NYS & Federal Essential Health Benefit	Deduct/Coins Unlimited visits	Not Covered
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	Deduct/Coins Limit of 680 hours per contract year	Not Covered
Substance Use Services NYS & Federal Essential Health Benefit	Deduct/Coins Excludes family therapy.	Not Covered
Office Visits - Diagnostic NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Medications Administered in Office NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Eye Exams - Diagnostic NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Hearing Evaluations Diagnostic NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Chiropractic Care NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered

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NYS Benchmark Plan  
Individual

Benefit Type	In-Network	Out-of-Network
Office & Outpatient Consultations NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Allergy Testing NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Allergy Treatment Includes Serum and Injections NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Hearing Evaluations Routine NYS Essential Health Benefit	Deduct/Coins	Not Covered
Hearing Aids NYS & Federal Essential Health Benefit	Deduct/Coins Single purchase once every 3 years	Not Covered
Cochlear Implants	Deduct/Coins One Per Ear Per Time Covered	Not Covered
<b>PREVENTIVE SERVICES</b>		
<b>Outpatient Facility &amp; Professional Provider</b>		
Adult Physical Examinations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Not Covered
Adult Immunizations Federal HCR Preventive Service NYS Essential Health Benefit Federal Essential Health Benefit	Covered in full	Not Covered
Well Child Visits and Immunizations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Routine Gynecological Exams Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Cervical Cytology Preventive only Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Prostate Cancer Screenings Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered
Mammogram Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Not Covered
Bone Density Testing Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/Coins	Not Covered
Colonoscopy Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/Coins	Not Covered
Family Planning HCR Preventive Service	Covered in full when HCR Preventive Deduct/Coins	Not Covered
<b>ADDITIONAL BENEFITS</b>		
Treatment of Diabetes Insulin & Supplies NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Diabetic Education NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Diabetic Equipment NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Autism Assistive Communication Devices (ACD) State Mandate NYS Essential Health Benefit	Deduct/Coins	Not Covered
Autologous Blood Banking NYS Essential Health Benefit	Deduct/Coins	Not Covered
Durable Medical Equipment (DME) NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered

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Individual

Benefit Type	In-Network	Out-of-Network
<b>External Prosthetics</b> NYS & Federal Essential Health Benefit	Deduct/Coins 1 external prosthetic device per limb per lifetime	Not Covered
<b>Orthotics</b> Foot orthotics included	Not Covered	Not Covered
<b>Medical Supplies</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>HEALTH &amp; WELLNESS</b> Incentive Programs NYS & Federal Essential Health Benefit	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months
<b>EMERGENCY SERVICES</b> Emergency Condition		
<b>Facility – Emergency Room</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Covered same as INN
<b>Physician’s Hospital Emergency Room Visit</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Covered same as INN
<b>Prehospital Emergency Services/Transportation</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Covered same as INN
<b>Freestanding Urgent Care Center</b> Art 28 Facility NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Physician’s Freestanding Urgent Care Center (Art 28 Facility)</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Physician Urgent Care Office Visit</b> NYS & Federal Essential Health Benefit	See office visit benefit	Not Covered
<b>VISION BENEFITS</b>		
<b>Eye Exams Routine - Adults</b>	Not Covered	Not Covered
<b>Eyewear - Adults</b>	Not Covered	Not Covered
<b>Eye Exams Routine - Pediatric</b> NYS & Federal Essential Health Benefit	Deduct/Coins 1 per 12 month period	Not Covered
<b>Eyewear - Pediatric</b> NYS & Federal Essential Health Benefit	Deduct/Coins Lenses or Contacts once in any 12 month period Frames once in any 12 month period	Not Covered
<b>DENTAL BENEFITS</b>		
<b>Adult Dental</b>	Not Covered	Not Covered
<b>Pediatric Dental - Emergency Care</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Pediatric Dental - Preventive</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Pediatric Dental - Endodontic</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Pediatric Dental - Prosthodontics</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Pediatric Dental - Orthodontics</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>PRESCRIPTION DRUGS</b> Closed Formulary		
<b>Generic or Tier 1/Tier 2/Tier 3</b> NYS & Federal Essential Health Benefit	Retail: 1 copay per 30 day supply Mail Order: Mail Order copay is 2.5 times retail for a 90 day supply	
<b>Platinum</b>	Copay: \$10 /\$30/\$60	Not Covered
<b>Gold</b>	Copay: \$10 /\$35/\$70	Not Covered
<b>Silver</b>	Copay: \$10 /\$35/\$70	Not Covered

**Excellus Health Plan, Inc.**  
 Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
 Community Rated

**2015 Individual Benefit Descriptions**

EXEC-1 (Rev.1) (Exclusive Provider Organization);  
 EXEC-2 (Rev.1) (Exclusive Provider Organization Child Only);  
 EXER-2 (Rev.1) (Out of Network Rider)  
 Bronze Standard  
 NYS Benchmark Plan  
 Individual

Benefit Type	In-Network	Out-of-Network
Silver 200-250 FPL	Copay: \$10 /\$35/\$70	Not Covered
Silver 150-200 FPL	Copay: \$9 /\$20/\$40	Not Covered
Silver 100-150 FPL	Copay: \$6/\$15/\$30	Not Covered
Native American 300 FPL	\$0 all tiers	Not Covered
Bronze	Deductible Copay: \$10 /\$35/\$70	Not Covered
WAITING PERIODS	None	
EXCLUSIONS	Standard Exclusions apply	

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**2015 Individual Benefit Descriptions**

EXEC-1 (Rev.1) (Exclusive Provider Organization);  
EXEC-2 (Rev.1) (Exclusive Provider Organization Child Only);  
EXER-2 (Rev.1) (Out of Network Rider)  
Copay Plan Non-Standard  
**Individual - Platinum**

Benefit Type	In-Network	Out-of-Network
<b>PROVIDER NETWORK &amp; SERVICE AREA</b>		
Provider Network Counties - BCBS	BCBS 31 counties only	
Provider Network Counties - Univera	39 Counties: BCBS 31 plus Univera 8	
BCBS Service Area	Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson	
Univera Service Area	Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Niagara; Orleans; Wyoming.	
<b>WHO IS COVERED</b>		
Type of Tiers – 4 Tier	Single - Subscriber or Child only 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family	
Dependent Coverage Federal Mandate	26 to end of month of birthday	
Dependents through age 29 State Mandate	Dependent Make Available	
Domestic Partner Coverage	Covered - standard	
<b>COST SHARING EXPENSES</b>		
Contract Year	Calendar Year	
Deductible · Single/ Family	None	Not Covered
4th Quarter Deductible Carry-Over Y/N	No	No
Copayment	\$15 PCP \$25 SPC	Not Covered
Coinsurance	None	Not Covered
Annual Out-of-Pocket Maximum	Single: \$6,350 Family: \$12,700	Not Covered
Annual Benefit Maximum Federal Mandate	None	
Lifetime Benefit Maximum Federal Mandate	None	
<b>HOSPITAL INPATIENT SERVICES</b>		
Inpatient Hospital Services NYS & Federal Essential Health Benefit	\$150 copay per admission Unlimited days	Not Covered
Mental Health Care Includes Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Substance Use Detoxification, Rehabilitation & Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Skilled Nursing Facility NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 200 days per contract year	Not Covered
Physical Rehabilitation includes habilitative services NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 1 consecutive 60 day stay per condition per lifetime	Not Covered
Maternity Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies.	Not Covered
Maternity Care – Routine Newborn Nursery NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Implanted Devices NYS & Federal Essential Health Benefit	Covered in Full	Not Covered
End of Life Care State Mandate NYS Essential Health Benefit	Inpatient Hospital cost share applies.	Not Covered

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EXEC-1 (Rev.1) (Exclusive Provider Organization);  
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EXER-2 (Rev.1) (Out of Network Rider)  
Copay Plan Non-Standard  
Individual - Platinum

Benefit Type	In-Network	Out-of-Network
Observation Stay NYS & Federal Essential Health Benefit	\$75 copay	Not Covered
HOME CARE NYS & Federal Essential Health Benefit	PCP Copay 40 visits per contract year	Not Covered
HOSPICE CARE NYS & Federal Essential Health Benefit	Inpatient: Inpatient Hospital cost share applies. Hospice facility or Home: Deduct/Coins 210 days per year, 5 family bereavement visits	Not Covered
<b>HOSPITAL OUTPATIENT SERVICES</b>		
Surgical Care including Surgicenters & Freestanding Facilities NYS & Federal Essential Health Benefit	\$75 Copay	Not Covered
Pre-admission/Pre-Operative Testing NYS & Federal Essential Health Benefit	Covered in Full	Not Covered
Diagnostic & Routine X-ray NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Advanced Imaging Services NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	PCP Copay	Not Covered
Radiation Therapy NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Chemotherapy NYS & Federal Essential Health Benefit	PCP Copay	Not Covered
Infusion Therapy NYS Essential Health Benefit	PCP Copay	Not Covered
Dialysis (all forms) NYS & Federal Essential Health Benefit	PCP Copay	Not covered except Out of Area only: Deduct/ PCP Copay per visit
Mental Health Care NYS & Federal Essential Health Benefit	Specialist Copay Unlimited visits	Not Covered
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	PCP Copay Limit of 680 hours per contract year	Not Covered
Substance Use Services NYS & Federal Essential Health Benefit	Specialist Copay Unlimited visits. Covers 20 visits per calendar year for family therapy.	Not Covered
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Pulmonary Rehabilitation NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
<b>PHYSICIAN SERVICES</b>		
Inpatient Hospital Surgery NYS Essential Health Benefit	Covered in full	Not Covered
Outpatient Hospital & Ambulatory Surgery NYS Essential Health Benefit	Covered in full	Not Covered
Office Surgery NYS Essential Health Benefit	PCP/Specialist Copay	Not Covered

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EXEC-1 (Rev.1) (Exclusive Provider Organization);  
EXEC-2 (Rev.1) (Exclusive Provider Organization Child Only);  
EXER-2 (Rev.1) (Out of Network Rider)  
Copay Plan Non-Standard  
Individual - Platinum

Benefit Type	In-Network	Out-of-Network
Anesthesia Includes IP, OP, OV and maternity NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Specialist Copay 60 visits per condition per lifetime	Not Covered
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Specialist Copay 60 visits per condition per lifetime	Not Covered
Pulmonary Rehabilitation NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Cardiac Rehabilitation NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Additional Surgical Opinion NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Second Medical Opinion for Cancer NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Maternity Care: Normal, Complications & Termination. NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Prenatal Care HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
In-Hospital Physician Visits NYS & Federal Essential Health Benefit	Covered in full	Not Covered
<b>PHYSICIAN OFFICE - OTHER SERVICES</b>		
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	PCP copay	Not Covered
Diagnostic & Routine X-ray NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Advanced Imaging Services NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Radiation Therapy NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Chemotherapy NYS & Federal Essential Health Benefit	PCP copay	Not Covered
Infusion Therapy NYS Essential Health Benefit	PCP copay	Not Covered
Dialysis (all forms) NYS & Federal Essential Health Benefit	PCP copay	Not covered except Out of Area only: Deduct/ PCP Copay per visit 10 visits per calendar yr
Mental Health Care NYS & Federal Essential Health Benefit	Specialist Copay Unlimited visits	Not Covered
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	Specialist Copay Limit of 680 hours per contract year	Not Covered
Substance Use Services NYS & Federal Essential Health Benefit	Specialist Copay Excludes family therapy.	Not Covered

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**2015 Individual Benefit Descriptions**

**EXEC-1 (Rev.1) (Exclusive Provider Organization);  
EXEC-2 (Rev.1) (Exclusive Provider Organization Child Only);  
EXER-2 (Rev.1) (Out of Network Rider)  
Copay Plan Non-Standard  
Individual - Platinum**

<b>Benefit Type</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Office Visits - Diagnostic NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Not Covered
Medications Administered in Office NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Not Covered
Eye Exams - Diagnostic NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Hearing Evaluations Diagnostic NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Chiropractic Care NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Office & Outpatient Consultations NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Not Covered
Allergy Testing NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Not Covered
Allergy Treatment Includes Serum and Injections NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Not Covered
Hearing Evaluations Routine NYS Essential Health Benefit	Specialist Copay	Not Covered
Hearing Aids NYS & Federal Essential Health Benefit	50% Coins Single purchase once every 3 years	Not Covered
Cochlear Implants	50% Coins One Per Ear Per Time Covered	Not Covered
<b>PREVENTIVE SERVICES</b>		
<b>Outpatient Facility &amp; Professional Provider</b>		
Adult Physical Examinations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Not Covered
Adult Immunizations Federal HCR Preventive Service NYS Essential Health Benefit Federal Essential Health Benefit	Covered in full	Not Covered
Well Child Visits and Immunizations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Routine Gynecological Exams Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Cervical Cytology Preventive only Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Prostate Cancer Screenings Federal HCR Preventive Service NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Not Covered
Mammogram Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Not Covered
Bone Density Testing Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive PCP/Specialist Copay	Not Covered
Colonoscopy Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive PCP/Specialist Copay	Not Covered
Family Planning HCR Preventive Service	Covered in full when HCR Preventive PCP/Specialist Copay	Not Covered
<b>ADDITIONAL BENEFITS</b>		

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EXEC-2 (Rev.1) (Exclusive Provider Organization Child Only);  
EXER-2 (Rev.1) (Out of Network Rider)  
Copay Plan Non-Standard  
Individual - Platinum

Benefit Type	In-Network	Out-of-Network
Treatment of Diabetes Insulin & Supplies NYS & Federal Essential Health Benefit	PCP copay	Not Covered
Diabetic Education NYS & Federal Essential Health Benefit	PCP copay	Not Covered
Diabetic Equipment NYS & Federal Essential Health Benefit	PCP copay	Not Covered
Autism Assistive Communication Devices (ACD) State Mandate NYS Essential Health Benefit	Specialist Copay	Not Covered
Autologous Blood Banking NYS Essential Health Benefit	50% Coins	Not Covered
Durable Medical Equipment (DME) NYS & Federal Essential Health Benefit	50% Coins	Not Covered
External Prosthetics NYS & Federal Essential Health Benefit	50% Coins 1 external prosthetic device per limb per lifetime	Not Covered
Orthotics Foot orthotics included	Not Covered	Not Covered
Medical Supplies NYS & Federal Essential Health Benefit	50% Coins	Not Covered
HEALTH & WELLNESS Incentive Programs NYS & Federal Essential Health Benefit	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months
<b>EMERGENCY SERVICES</b>		
<b>Emergency Condition</b>		
Facility – Emergency Room NYS & Federal Essential Health Benefit	\$75 copay	Covered same as INN
Physician’s Hospital Emergency Room Visit NYS & Federal Essential Health Benefit	Covered in full	Covered same as INN
Prehospital Emergency Services/Transportation NYS & Federal Essential Health Benefit	\$75 copay	Covered same as INN
Freestanding Urgent Care Center Art 28 Facility NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered
Physician’s Freestanding Urgent Care Center (Art 28 Facility) NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Physician Urgent Care Office Visit NYS & Federal Essential Health Benefit	See office visit benefit	Not Covered
<b>VISION BENEFITS</b>		
Eye Exams Routine - Adults	Not Covered	Not Covered
Eyewear - Adults	Not Covered	Not Covered
Eye Exams Routine - Pediatric NYS & Federal Essential Health Benefit	Specialist Copay 1 per 12 month period	Not Covered
Eyewear - Pediatric NYS & Federal Essential Health Benefit	50% Coins Lenses or Contacts once in any 12 month period Frames once in any 12 month period	Not Covered
<b>DENTAL BENEFITS</b>		
Adult Dental	Not Covered	Not Covered
Pediatric Dental - Emergency Care NYS & Federal Essential Health Benefit	20% Coins	Not Covered

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 EXEC-2 (Rev.1) (Exclusive Provider Organization Child Only);  
 EXER-2 (Rev.1) (Out of Network Rider)  
 Copay Plan Non-Standard  
 Individual - Platinum

Benefit Type	In-Network	Out-of-Network
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	20% Coins	Not Covered
Pediatric Dental - Routine NYS & Federal Essential Health Benefit	20% Coins	Not Covered
Pediatric Dental - Endodontic NYS & Federal Essential Health Benefit	50% Coins	Not Covered
Pediatric Dental - Prosthodontics NYS & Federal Essential Health Benefit	50% Coins	Not Covered
Pediatric Dental - Orthodontics NYS & Federal Essential Health Benefit	50% Coins	Not Covered
<b>PRESCRIPTION DRUGS</b>		
Closed Formulary		
Generic or Tier 1/Tier 2/Tier 3 NYS & Federal Essential Health Benefit	Retail: 1 copay per 30 day supply Mail Order: Mail Order copay is 2.5 times retail for a 90	
Platinum	Copay: \$5 /\$25/\$50	Not Covered
<b>WAITING PERIODS</b>	None	
<b>EXCLUSIONS</b>	Standard Exclusions apply	

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EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [no Pediatric Dental]  
EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [with Pediatric Dental]  
Platinum Individual PPO Standard  
Out of Network Rider  
Individual - OFF Exchange

Benefit Type	In-Network	Out-of-Network
<b>PROVIDER NETWORK &amp; SERVICE AREA</b>		
Provider Network Counties - BCBS	BCBS 31 counties only	
Provider Network Counties - Univera	39 Counties: BCBS 31 plus Univera 8	
BCBS Service Area	Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson	
Univera Service Area	Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Niagara; Orleans; Wyoming.	
<b>WHO IS COVERED</b>		
Type of Tiers – 4 Tier	Single - Subscriber or Child only 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family	
Dependent Coverage Federal Mandate	26 to end of month of birthday	
Dependents through age 29 State Mandate	Dependent Make Available	
Domestic Partner Coverage	Covered - standard	
<b>COST SHARING EXPENSES</b>		
Contract Year	Calendar Year	
Deductible · Single/ Family	Single: \$0 Family = 2X single	Single: \$1,000 Family: \$2,000
4th Quarter Deductible Carry-Over Y/N	No	No
Copayment	\$15 PCP/ \$35 SPC	None
Coinsurance	None	20%
Annual Out-of-Pocket Maximum	Single: \$2,000 Family = 2X single	Single: \$3,000 Family: \$5,000
Annual Benefit Maximum Federal Mandate	None	
Lifetime Benefit Maximum Federal Mandate	None	
<b>HOSPITAL INPATIENT SERVICES</b>		
Inpatient Hospital Services NYS & Federal Essential Health Benefit	\$500 copay per admission	Deduct/Coins
Mental Health Care Includes Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Deduct/ 10% Coins Unlimited days
Substance Use Detoxification, Rehabilitation & Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Deduct/ 10% Coins Unlimited days
Skilled Nursing Facility NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 200 days per contract year	Inpatient Hospital cost share applies. 200 days per contract year
Physical Rehabilitation includes habilitative services NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 1 consecutive 60 day stay per condition per lifetime	Inpatient Hospital cost share applies. 1 consecutive 60 day stay per condition per lifetime
Maternity Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies.	Inpatient Hospital cost share applies.
Maternity Care – Routine Newborn Nursery NYS & Federal Essential Health Benefit	Covered in Full	Deduct/Coins
End of Life Care State Mandate NYS Essential Health Benefit	Inpatient Hospital cost share applies.	Inpatient Hospital cost share applies.
Observation Stay NYS & Federal Essential Health Benefit	\$100 copay	Deduct/Coins
HOME CARE NYS & Federal Essential Health Benefit	PCP Copay 40 visits per contract year	Deduct/Coins 40 visits per contract year

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EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [no Pediatric Dental]  
EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [with Pediatric Dental]  
Platinum Individual PPO Standard  
Out of Network Rider  
Individual - OFF Exchange

Benefit Type	In-Network	Out-of-Network
<b>HOSPICE CARE</b> NYS & Federal Essential Health Benefit	Inpatient: Inpatient Hospital cost share applies. Hospice facility or Home: Deduct/ PCP copay per visit 210 days per year, 5 family bereavement visits	Deduct/Coins
<b>HOSPITAL OUTPATIENT SERVICES</b>		
<b>Surgical Care including Surgicenters &amp; Freestanding Facilities</b> NYS & Federal Essential Health Benefit	\$100 copay	Deduct/Coins
<b>Pre-admission/Pre-Operative Testing</b> NYS & Federal Essential Health Benefit	Covered in full	Deduct/Coins
<b>Diagnostic &amp; Routine X-ray</b> NYS & Federal Essential Health Benefit	Specialist Copay	Deduct/Coins
<b>Advanced Imaging Services</b> NYS & Federal Essential Health Benefit	Specialist Copay	Deduct/Coins
<b>Diagnostic &amp; Routine Laboratory and Pathology</b> NYS & Federal Essential Health Benefit	Specialist Copay	Deduct/Coins
<b>Radiation Therapy</b> NYS & Federal Essential Health Benefit	PCP Copay	Deduct/Coins
<b>Chemotherapy</b> NYS & Federal Essential Health Benefit	PCP Copay	Deduct/Coins
<b>Infusion Therapy</b> NYS Essential Health Benefit	PCP Copay	Deduct/Coins
<b>Dialysis (all forms)</b> NYS & Federal Essential Health Benefit	PCP Copay	Deduct/Coins
<b>Mental Health Care</b> NYS & Federal Essential Health Benefit	PCP Copay Unlimited visits	Deduct/ 10% Coins Unlimited visits
<b>Autism Applied Behavior Analysis</b> State Mandate NYS Essential Health Benefit	PCP Copay Limit of 680 hours per contract year	Deduct/Coins Limit of 680 hours per contract year
<b>Substance Use Services</b> NYS & Federal Essential Health Benefit	PCP Copay Unlimited visits. Covers 20 visits per calendar year for family therapy.	Deduct/ 10% Coins Unlimited visits. Covers 20 visits per calendar year for family therapy.
<b>Covered Therapies - Rehabilitation</b> Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	\$25 copay 60 visits per condition per lifetime	Deduct/Coins 60 visits per condition per lifetime
<b>Covered Therapies - Habilitation</b> Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	\$25 copay 60 visits per condition per lifetime	Deduct/Coins 60 visits per condition per lifetime
<b>Pulmonary Rehabilitation</b> NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit	Not Covered
<b>PHYSICIAN SERVICES</b>		
<b>Inpatient Hospital Surgery</b> NYS Essential Health Benefit	\$100 Copay	Deduct/Coins
<b>Outpatient Hospital &amp; Ambulatory Surgery</b> NYS Essential Health Benefit	\$100 Copay	Deduct/Coins
<b>Office Surgery</b> NYS Essential Health Benefit	PCP/Specialist Copay	Deduct/Coins
<b>Anesthesia</b> Includes IP, OP, OV and maternity NYS & Federal Essential Health Benefit	Covered in Full	Deduct/Coins

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EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [no Pediatric Dental]  
EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [with Pediatric Dental]  
Platinum Individual PPO Standard  
Out of Network Rider  
Individual - OFF Exchange

Benefit Type	In-Network	Out-of-Network
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	\$25 copay 60 visits per condition per lifetime	Deduct/Coins 60 visits per condition per lifetime
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	\$25 copay 60 visits per condition per lifetime	Deduct/Coins 60 visits per condition per lifetime
Pulmonary Rehabilitation NYS & Federal Essential Health Benefit	PCP Copay	Deduct/Coins
Cardiac Rehabilitation NYS & Federal Essential Health Benefit	PCP Copay	Deduct/Coins
Additional Surgical Opinion NYS & Federal Essential Health Benefit	Specialist Copay	Deduct/Coins
Second Medical Opinion for Cancer NYS & Federal Essential Health Benefit	Specialist Copay	Deduct/Coins
Maternity Care: Normal, Complications & Termination. NYS & Federal Essential Health Benefit	\$100 copay	Deduct/Coins
Prenatal Care HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Deduct/Coins
In-Hospital Physician Visits NYS & Federal Essential Health Benefit	Covered in full	Deduct/Coins
<b>PHYSICIAN OFFICE - OTHER SERVICES</b>		
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Deduct/Coins
Diagnostic & Routine X-ray NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Deduct/Coins
Advanced Imaging Services NYS & Federal Essential Health Benefit	Specialist Copay	Deduct/Coins
Radiation Therapy NYS & Federal Essential Health Benefit	PCP copay	Deduct/Coins
Chemotherapy NYS & Federal Essential Health Benefit	PCP copay	Deduct/Coins
Infusion Therapy NYS Essential Health Benefit	PCP copay	Deduct/Coins
Dialysis (all forms) NYS & Federal Essential Health Benefit	PCP copay	Deduct/Coins
Mental Health Care NYS & Federal Essential Health Benefit	PCP Copay Unlimited visits	Deduct/ 10% Coins Unlimited visits
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	PCP Copay Limit of 680 hours per contract year	Deduct/Coins Limit of 680 hours per contract year
Substance Use Services NYS & Federal Essential Health Benefit	PCP Copay Excludes family therapy.	Deduct/ 10% Coins Unlimited visits, Excludes family therapy.
Office Visits - Diagnostic NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Deduct/Coins
Medications Administered in Office NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Deduct/Coins
Eye Exams - Diagnostic NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Deduct/Coins
Hearing Evaluations Diagnostic NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Deduct/Coins
Chiropractic Care NYS & Federal Essential Health Benefit	Specialist copay	Deduct/Coins
Office & Outpatient Consultations NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Deduct/Coins

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**

EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [no Pediatric Dental]  
EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [with Pediatric Dental]  
Platinum Individual PPO Standard  
Out of Network Rider  
Individual - OFF Exchange

Benefit Type	In-Network	Out-of-Network
Allergy Testing NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Deduct/Coins
Allergy Treatment Includes Serum and Injections NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Deduct/Coins
Hearing Evaluations Routine NYS Essential Health Benefit	Specialist Copay	Deduct/Coins
Hearing Aids NYS & Federal Essential Health Benefit	10% Coins Single purchase once every 3 years	Deduct/Coins Single purchase once every 3 years
Cochlear Implants	10% Coins One Per Ear Per Time Covered	Deduct/Coins One Per Ear Per Time Covered
<b>PREVENTIVE SERVICES</b>		
<b>Outpatient Facility &amp; Professional Provider</b>		
Adult Physical Examinations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Deduct/Coins 1 per contract year
Adult Immunizations Federal HCR Preventive Service NYS Essential Health Benefit Federal Essential Health Benefit	Covered in full	Deduct/Coins
Well Child Visits and Immunizations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Deduct/Coins
Routine Gynecological Exams Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Deduct/Coins
Cervical Cytology Preventive only Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Deduct/Coins
Prostate Cancer Screenings Federal HCR Preventive Service NYS & Federal Essential Health Benefit	PCP/Specialist Copay	Deduct/Coins
Mammogram Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Deduct/Coins
Bone Density Testing Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive PCP/Specialist Copay	Deduct/Coins
Colonoscopy Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive PCP/Specialist Copay	Deduct/Coins
Family Planning HCR Preventive Service	Covered in full when HCR Preventive PCP/Specialist Copay	Deduct/Coins
<b>ADDITIONAL BENEFITS</b>		
Treatment of Diabetes Insulin & Supplies NYS & Federal Essential Health Benefit	PCP copay	Deduct/Coins
Diabetic Education NYS & Federal Essential Health Benefit	PCP copay	Deduct/Coins
Diabetic Equipment NYS & Federal Essential Health Benefit	PCP copay	Deduct/Coins
Autism Assistive Communication Devices (ACD) State Mandate NYS Essential Health Benefit	PCP copay	Deduct/Coins
Autologous Blood Banking NYS Essential Health Benefit	10% Coins	Deduct/Coins
Durable Medical Equipment (DME) NYS & Federal Essential Health Benefit	10% Coins	Deduct/Coins

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**

EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [no Pediatric Dental]  
EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [with Pediatric Dental]  
Platinum Individual PPO Standard  
Out of Network Rider  
Individual - OFF Exchange

Benefit Type	In-Network	Out-of-Network
External Prosthetics NYS & Federal Essential Health Benefit	10% Coins 1 external prosthetic device per limb per lifetime	Deduct/Coins 1 external prosthetic device per limb per lifetime
Orthotics Foot orthotics included	Not Covered	Not Covered
Medical Supplies NYS & Federal Essential Health Benefit	10% Coins	Deduct/Coins
HEALTH & WELLNESS Incentive Programs NYS & Federal Essential Health Benefit	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months
<b>EMERGENCY SERVICES</b> Emergency Condition		
Facility – Emergency Room NYS & Federal Essential Health Benefit	\$100 copay	\$100 copay
Physician’s Hospital Emergency Room Visit NYS & Federal Essential Health Benefit	Covered in full	Covered in full
Prehospital Emergency Services/Transportation NYS & Federal Essential Health Benefit	\$100 copay	Deduct/Coins
Freestanding Urgent Care Center Art 28 Facility NYS & Federal Essential Health Benefit	\$55 copay	Deduct/Coins
Physician’s Freestanding Urgent Care Center (Art 28 Facility) NYS & Federal Essential Health Benefit	Covered in full	Deduct/Coins
Physician Urgent Care Office Visit NYS & Federal Essential Health Benefit	See office visit benefit	See office visit benefit
<b>VISION BENEFITS</b>		
Eye Exams Routine - Adults	Not Covered	Not Covered
Eyewear - Adults	Not Covered	Not Covered
Eye Exams Routine - Pediatric NYS & Federal Essential Health Benefit	PCP Copay 1 per 12 month period	Deduct/Coins 1 per 12 month period
Eyewear - Pediatric NYS & Federal Essential Health Benefit	10% Coins  Lenses or Contacts once in any 12 month period Frames once in any 12 month period	Deduct/Coins  Lenses or Contacts once in any 12 month period Frames once in any 12 month period
<b>DENTAL BENEFITS</b>		
Adult Dental	Not Covered	Not Covered
Pediatric Dental - Emergency Care NYS & Federal Essential Health Benefit	PCP Copay	Deduct/Coins
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	PCP Copay	Deduct/Coins
Pediatric Dental - Routine NYS & Federal Essential Health Benefit	PCP Copay	Deduct/Coins
Pediatric Dental - Endodontic NYS & Federal Essential Health Benefit	PCP Copay	Deduct/Coins
Pediatric Dental - Prosthodontics NYS & Federal Essential Health Benefit	PCP Copay	Deduct/Coins
Pediatric Dental - Orthodontics NYS & Federal Essential Health Benefit	PCP Copay	Deduct/Coins
<b>PRESCRIPTION DRUGS</b> Closed Formulary		

**Excellus Health Plan, Inc.**  
 Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
 Community Rated

**2015 Individual Benefit Descriptions**

EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [no Pediatric Dental]  
 EXEC-1 (Rev.1), EXEC-2 (Rev.1), EXER-1 (Rev.1), EXER-2 (Rev.1), [with Pediatric Dental]  
 Platinum Individual PPO Standard  
 Out of Network Rider  
 Individual - OFF Exchange

Benefit Type	In-Network	Out-of-Network
Generic or Tier 1/Tier 2/Tier 3 NYS & Federal Essential Health Benefit	Retail: 1 copay per 30 day supply Mail Order: Mail Order copay is 2.5 times retail for a 90 day supply	
Platinum	Copay: \$10 /\$30/\$60	Not Covered
WAITING PERIODS	None	
EXCLUSIONS	Standard Exclusions apply	

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**

**EXEC-1 (Rev.1) (Exclusive Provider Organization)  
Hybrid A Plans Non-Standard  
Individual - Gold**

Benefit Type	In-Network	Out-of-Network
<b>PROVIDER NETWORK &amp; SERVICE AREA</b>		
Provider Network Counties - BCBS	BCBS 31 counties only	
Provider Network Counties - Univera	39 Counties: BCBS 31 plus Univera 8	
BCBS Service Area	Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson	
Univera Service Area	Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Niagara; Orleans; Wyoming;	
<b>WHO IS COVERED</b>		
Type of Tiers – 4 Tier	Single - Subscriber or Child only 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family	
Dependent Coverage Federal Mandate	26 to end of month of birthday	
Dependents through age 29 State Mandate	Dependent Make Available	
Domestic Partner Coverage	Covered - standard	
<b>COST SHARING EXPENSES</b>		
Contract Year	Calendar Year	
Deductible · Single/ Family	Single: \$600 Family: \$1,200	Not Covered
4th Quarter Deductible Carry-Over Y/N	No	No
Copayment	\$25 PCP \$40 SPC	Not Covered
Coinsurance	None	Not Covered
Annual Out-of-Pocket Maximum	Single: \$4,000 Family: \$8,000 Family = 2X single	Not Covered
Annual Benefit Maximum Federal Mandate	None	
Lifetime Benefit Maximum Federal Mandate	None	
<b>HOSPITAL INPATIENT SERVICES</b>		
Inpatient Hospital Services NYS & Federal Essential Health Benefit	Deduct/ \$750 copay per admission	Not Covered
Mental Health Care Includes Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Substance Use Detoxification, Rehabilitation & Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Skilled Nursing Facility NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 200 days per contract year	Not Covered
Physical Rehabilitation includes habilitative services NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 1 consecutive 60 day stay per condition per lifetime	Not Covered
Maternity Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies.	Not Covered
Maternity Care – Routine Newborn Nursery NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	Not Covered
Internal Prosthetic (Implanted Devices) NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	Not Covered
End of Life Care State Mandate NYS Essential Health Benefit	Inpatient Hospital cost share applies.	Not Covered

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**

**EXEC-1 (Rev.1) (Exclusive Provider Organization)  
Hybrid A Plans Non-Standard  
Individual - Gold**

<b>Benefit Type</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Observation Stay NYS &amp; Federal Essential Health Benefit</b>	Deduct/\$250 copay	Not Covered
<b>HOME CARE NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP Copay 40 visits per contract year	Not Covered
<b>HOSPICE CARE NYS &amp; Federal Essential Health Benefit</b>	Inpatient: Inpatient Hospital cost share applies. Hospice facility or Home: Deduct/ PCP copay per visit 210 days per year, 5 family bereavement visits	Not Covered
<b>HOSPITAL OUTPATIENT SERVICES</b>		
<b>Surgical Care including Surgicenters &amp; Freestanding Facilities NYS &amp; Federal Essential Health Benefit</b>	Deduct/ \$250 Copay	Not Covered
<b>Pre-admission/Pre-Operative Testing NYS &amp; Federal Essential Health Benefit</b>	Deduct/ \$0 Copay	Not Covered
<b>Diagnostic &amp; Routine X-ray NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Advanced Imaging Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Diagnostic &amp; Routine Laboratory and Pathology NYS &amp; Federal Essential Health Benefit</b>	Deduct/PCP Copay	Not Covered
<b>Radiation Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Chemotherapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/PCP Copay	Not Covered
<b>Infusion Therapy NYS Essential Health Benefit</b>	Deduct/PCP Copay	Not Covered
<b>Dialysis (all forms) NYS &amp; Federal Essential Health Benefit</b>	Deduct/PCP Copay	Not covered except Out of Area only: Deduct/ PCP Copay per visit
<b>Mental Health Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay Unlimited visits	Not Covered
<b>Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit</b>	Deduct/Specialist Copay Limit of 680 hours per contract year	Not Covered
<b>Substance Use Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay Unlimited visits. Covers 20 visits per calendar year for family therapy.	Not Covered
<b>Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay 60 visits per condition per lifetime	Not Covered
<b>Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay 60 visits per condition per lifetime	Not Covered
<b>Pulmonary Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Not Covered
<b>PHYSICIAN SERVICES</b>		
<b>Inpatient Hospital Surgery NYS Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>Outpatient Hospital &amp; Ambulatory Surgery NYS Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>Office Surgery NYS Essential Health Benefit</b>	Deduct/ PCP/Specialist	Not Covered
<b>Anesthesia Includes IP, OP, OV and maternity NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Not Covered

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**

**EXEC-1 (Rev.1) (Exclusive Provider Organization)  
Hybrid A Plans Non-Standard  
Individual - Gold**

<b>Benefit Type</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay 60 visits per condition per lifetime	Not Covered
<b>Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay 60 visits per condition per lifetime	Not Covered
<b>Pulmonary Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Not Covered
<b>Cardiac Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Not Covered
<b>Additional Surgical Opinion NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Second Medical Opinion for Cancer NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Maternity Care: Normal, Complications &amp; Termination. NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>Prenatal Care HCR Preventive Service NYS &amp; Federal Essential Health Benefit</b>	Covered in full	Not Covered
<b>In-Hospital Physician Visits NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>PHYSICIAN OFFICE - OTHER SERVICES</b>		
<b>Diagnostic &amp; Routine Laboratory and Pathology NYS &amp; Federal Essential Health Benefit</b>	Deduct/PCP Copay	Not Covered
<b>Diagnostic &amp; Routine X-ray NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Advanced Imaging Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Radiation Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Chemotherapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay	Not Covered
<b>Infusion Therapy NYS Essential Health Benefit</b>	Deduct/ PCP copay	Not Covered
<b>Dialysis (all forms) NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay	Not covered except Out of Area only: Deduct/ PCP Copay per visit
<b>Mental Health Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay Unlimited visits	Not Covered
<b>Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit</b>	Deduct/Specialist Copay Limit of 680 hours per contract year	Not Covered
<b>Substance Use Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay Excludes family therapy.	Not Covered
<b>Office Visits - Diagnostic NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Not Covered
<b>Medications Administered in Office NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Not Covered
<b>Eye Exams - Diagnostic NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Hearing Evaluations Diagnostic NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Not Covered
<b>Chiropractic Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist copay	Not Covered
<b>Office &amp; Outpatient Consultations NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Not Covered
<b>Allergy Testing NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Not Covered

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**

**EXEC-1 (Rev.1) (Exclusive Provider Organization)  
Hybrid A Plans Non-Standard  
Individual - Gold**

<b>Benefit Type</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Allergy Treatment</b> Includes Serum and Injections NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered
<b>Hearing Evaluations Routine</b> NYS Essential Health Benefit	Deduct/ Specialist copay	Not Covered
<b>Hearing Aids</b> NYS & Federal Essential Health Benefit	Deduct/50% Coins Single purchase once every 3 years	Not Covered
<b>Cochlear Implants</b>	Deduct/50% Coins One Per Ear Per Time Covered	Not Covered
<b>PREVENTIVE SERVICES</b>		
<b>Outpatient Facility &amp; Professional Provider</b>		
<b>Adult Physical Examinations</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Not Covered
<b>Adult Immunizations</b> Federal HCR Preventive Service NYS Essential Health Benefit Federal Essential Health Benefit	Covered in full	Not Covered
<b>Well Child Visits and Immunizations</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
<b>Routine Gynecological Exams</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
<b>Cervical Cytology Preventive only</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
<b>Prostate Cancer Screenings</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered
<b>Mammogram Screening</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Not Covered
<b>Bone Density Testing</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Not Covered
<b>Colonoscopy Screening</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Not Covered
<b>Family Planning</b> HCR Preventive Service	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Not Covered
<b>ADDITIONAL BENEFITS</b>		
<b>Treatment of Diabetes Insulin &amp; Supplies</b> NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered
<b>Diabetic Education</b> NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered
<b>Diabetic Equipment</b> NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered
<b>Autism Assistive Communication Devices (ACD)</b> State Mandate NYS Essential Health Benefit	Deduct/Specialist Copay	Not Covered
<b>Autologous Blood Banking</b> NYS Essential Health Benefit	Deduct/50% Coins	Not Covered
<b>Durable Medical Equipment (DME)</b> NYS & Federal Essential Health Benefit	Deduct/50% Coins	Not Covered
<b>External Prosthetics</b> NYS & Federal Essential Health Benefit	Deduct/50% Coins 1 external prosthetic device per limb per lifetime	Not Covered
<b>Orthotics</b> Foot orthotics included	Not Covered	Not Covered
<b>Medical Supplies</b> NYS & Federal Essential Health Benefit	Deduct/50% Coins	Not Covered

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**

**EXEC-1 (Rev.1) (Exclusive Provider Organization)  
Hybrid A Plans Non-Standard  
Individual - Gold**

Benefit Type	In-Network	Out-of-Network
<b>HEALTH &amp; WELLNESS</b> Incentive Programs NYS & Federal Essential Health Benefit	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months
<b>EMERGENCY SERVICES</b> Emergency Condition		
Facility – Emergency Room NYS & Federal Essential Health Benefit	Deduct/\$250 copay	Deduct/\$250 copay
Physician’s Hospital Emergency Room Visit NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	Deduct/ \$0 Copay
Prehospital Emergency Services/Transportation NYS & Federal Essential Health Benefit	Deduct/\$250 copay	Deduct/\$250 copay
Freestanding Urgent Care Center Art 28 Facility NYS & Federal Essential Health Benefit	Deduct/Specialist Copay	Not Covered
Physician’s Freestanding Urgent Care Center (Art 28 Facility) NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	Not Covered
Physician Urgent Care Office Visit NYS & Federal Essential Health Benefit	See office visit benefit	Not Covered
<b>VISION BENEFITS</b>		
Eye Exams Routine - Adults	Not Covered	Not Covered
Eyewear - Adults	Not Covered	Not Covered
Eye Exams Routine - Pediatric NYS & Federal Essential Health Benefit	Deduct/Specialist Copay 1 per 12 month period	Not Covered
Eyewear - Pediatric NYS & Federal Essential Health Benefit	Deduct/50%Coins Lenses or Contacts once in any 12 month period Frames once in any 12 month period	Not Covered
<b>DENTAL BENEFITS</b>		
Adult Dental	Not Covered	Not Covered
Pediatric Dental - Emergency Care NYS & Federal Essential Health Benefit	Deduct/20% Coins	Not Covered
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	Deduct/20% Coins	Not Covered
Pediatric Dental - Routine NYS & Federal Essential Health Benefit	Deduct/20% Coins	Not Covered
Pediatric Dental - Endodontic NYS & Federal Essential Health Benefit	Deduct/50% Coins	Not Covered
Pediatric Dental - Prosthodontics NYS & Federal Essential Health Benefit	Deduct/50% Coins	Not Covered
Pediatric Dental - Orthodontics NYS & Federal Essential Health Benefit	Deduct/50% Coins	Not Covered
<b>PRESCRIPTION DRUGS</b> Closed Formulary		
Generic or Tier 1/Tier 2/Tier 3 NYS & Federal Essential Health Benefit	Retail: 1 copay per 30 day supply Mail Order: Mail Order copay is 2.5 times retail for a 90 day supply	
Gold	Copay: \$5 /\$35/\$70	Not Covered
<b>WAITING PERIODS</b>	None	
<b>EXCLUSIONS</b>	Standard Exclusions apply	

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**

EXEC-1 (Rev.1)  
HDHP Plans Non-Standard  
Individual - [Silver; Bronze]

Benefit Type	In-Network	Out-of-Network
<b>PROVIDER NETWORK &amp; SERVICE AREA</b>		
Provider Network Counties - BCBS	BCBS 31 counties only	
Provider Network Counties - Univera	39 Counties: BCBS 31 plus Univera 8	
BCBS Service Area	Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson	
Univera Service Area	Allegany; Cattaraugus; Chautauqua; Erie; Genesee; Niagara; Orleans; Wyoming;	
<b>WHO IS COVERED</b>		
Type of Tiers – 4 Tier	Single - Subscriber or Child only 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family	
Dependent Coverage Federal Mandate	26 to end of month of birthday	
Dependents through age 29 State Mandate	Dependent Make Available	
Domestic Partner Coverage	Covered - standard	
<b>COST SHARING EXPENSES</b>		
Contract Year	Calendar Year	
Deductible · Single/ Family	Bronze Select: Single: \$[4,500] Silver Select:Single: \$[2,000] Silver CSR: \$[0, 250,1200] Family = 2X single	Not Covered
4th Quarter Deductible Carry-Over Y/N	No	No
Copayment	None	Not Covered
Coinsurance	Silver Select: 20% Bronze Select: 50% Silver CSR: %[5, 20, 20]	Not Covered
Annual Out-of-Pocket Maximum	Bronze Select: Single: \$[6,350] Silver Select:Single: \$[5,000] Silver CSR: \$[1,650, 1,650,3,000] Family = 2X single	Not Covered
Annual Benefit Maximum Federal Mandate	None	
Lifetime Benefit Maximum Federal Mandate	None	
<b>HOSPITAL INPATIENT SERVICES</b>		
Inpatient Hospital Services NYS & Federal Essential Health Benefit	Deduct/Coins Unlimited days	Not Covered
Mental Health Care Includes Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Substance Use Detoxification, Rehabilitation & Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Skilled Nursing Facility NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 200 days per contract year	Not Covered
Physical Rehabilitation includes habilitative services NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 1 consecutive 60 day stay per condition per lifetime	Not Covered
Maternity Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies.	Not Covered
Maternity Care – Routine Newborn Nursery NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Internal Prosthetic (Implanted Devices) NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies.	Not Covered

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HDHP Plans Non-Standard  
Individual - [Silver; Bronze]

Benefit Type	In-Network	Out-of-Network
End of Life Care State Mandate NYS Essential Health Benefit	Inpatient Hospital cost share applies.	Not Covered
Observation Stay NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
HOME CARE NYS & Federal Essential Health Benefit	Deduct/Coins 40 visits per contract year	Not Covered
HOSPICE CARE NYS & Federal Essential Health Benefit	Inpatient: Deduct/Coins Hospice facility or Home: Deduct/Coins 210 days per year, 5 family bereavement visits	Not Covered
<b>HOSPITAL OUTPATIENT SERVICES</b>		
Surgical Care including Surgicenters & Freestanding Facilities NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Pre-admission/Pre-Operative Testing NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Diagnostic & Routine X-ray NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Advanced Imaging Services NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Radiation Therapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Chemotherapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Infusion Therapy NYS Essential Health Benefit	Deduct/Coins	Not Covered
Dialysis (all forms) NYS & Federal Essential Health Benefit	Deduct/Coins	Not covered except Out of Area only: Deduct/ PCP Copay per visit
Mental Health Care NYS & Federal Essential Health Benefit	Deduct/Coins Unlimited visits	Not Covered
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	Deduct/Coins Limit of 680 hours per contract year	Not Covered
Substance Use Services NYS & Federal Essential Health Benefit	Deduct/Coins Unlimited visits. Covers 20 visits per calendar year for family therapy.	Not Covered
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Pulmonary Rehabilitation NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>PHYSICIAN SERVICES</b>		
Inpatient Hospital Surgery NYS Essential Health Benefit	Deduct/Coins	Not Covered
Outpatient Hospital & Ambulatory Surgery NYS Essential Health Benefit	Deduct/Coins	Not Covered
Office Surgery NYS Essential Health Benefit	Deduct/Coins	Not Covered
Anesthesia Includes IP, OP, OV and maternity NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered

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Benefit Type	In-Network	Out-of-Network
<b>Covered Therapies - Rehabilitation</b> Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Coins 60 visits per condition per lifetime	Not Covered
<b>Covered Therapies - Habilitation</b> Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Coins 60 visits per condition per lifetime	Not Covered
<b>Pulmonary Rehabilitation</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Cardiac Rehabilitation</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Additional Surgical Opinion</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Second Medical Opinion for Cancer</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Maternity Care: Normal, Complications &amp; Termination.</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Prenatal Care</b> HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
<b>In-Hospital Physician Visits</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>PHYSICIAN OFFICE - OTHER SERVICES</b>		
<b>Diagnostic &amp; Routine Laboratory and Pathology</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Diagnostic &amp; Routine X-ray</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Advanced Imaging Services</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Radiation Therapy</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Chemotherapy</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Infusion Therapy</b> NYS Essential Health Benefit	Deduct/Coins	Not Covered
<b>Dialysis (all forms)</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not covered except Out of Area only: Deduct/ PCP Copay per visit 10 visits per calendar yr
<b>Mental Health Care</b> NYS & Federal Essential Health Benefit	Deduct/Coins Unlimited visits	Not Covered
<b>Autism Applied Behavior Analysis</b> State Mandate NYS Essential Health Benefit	Deduct/Coins Limit of 680 hours per contract year	Not Covered
<b>Substance Use Services</b> NYS & Federal Essential Health Benefit	Deduct/Coins Excludes family therapy.	Not Covered
<b>Office Visits - Diagnostic</b> NYS & Federal Essential Health Benefit	Bronze: Deduct/Coins Catastrophic: 3 primary visits CIF, 4th & after Deduct/Coins	Not Covered
<b>Medications Administered in Office</b> NYS & Federal Essential Health Benefit	Bronze: Deduct/Coins Catastrophic: 3 primary visits CIF, 4th & after	Not Covered
<b>Eye Exams - Diagnostic</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Hearing Evaluations Diagnostic</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered

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Benefit Type	In-Network	Out-of-Network
Chiropractic Care NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Office & Outpatient Consultations NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Allergy Testing NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Allergy Treatment Includes Serum and Injections NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Hearing Evaluations Routine NYS Essential Health Benefit	Deduct/Coins	Not Covered
Hearing Aids NYS & Federal Essential Health Benefit	Deduct/50% Coins Single purchase once every 3 years	Not Covered
Cochlear Implants	Deduct/50% Coins One Per Ear Per Time Covered	Not Covered
<b>PREVENTIVE SERVICES</b>		
<b>Outpatient Facility &amp; Professional Provider</b>		
Adult Physical Examinations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Not Covered
Adult Immunizations Federal HCR Preventive Service NYS Essential Health Benefit Federal Essential Health Benefit	Covered in full	Not Covered
Well Child Visits and Immunizations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Routine Gynecological Exams Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Cervical Cytology Preventive only Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Not Covered
Prostate Cancer Screenings Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Not Covered
Mammogram Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Not Covered
Bone Density Testing Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/Coins	Not Covered
Colonoscopy Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/Coins	Not Covered
Family Planning HCR Preventive Service	Covered in full when HCR Preventive Deduct/Coins	Not Covered
<b>ADDITIONAL BENEFITS</b>		
Treatment of Diabetes Insulin & Supplies NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Diabetic Education NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Diabetic Equipment NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Autism Assistive Communication Devices (ACD) State Mandate NYS Essential Health Benefit	Deduct/Coins	Not Covered
Autologous Blood Banking NYS Essential Health Benefit	Deduct/50% Coins	Not Covered

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Benefit Type	In-Network	Out-of-Network
Durable Medical Equipment (DME) NYS & Federal Essential Health Benefit	Deduct/50% Coins	Not Covered
External Prosthetics NYS & Federal Essential Health Benefit	Deduct/50% Coins 1 external prosthetic device per limb per lifetime	Not Covered
Orthotics Foot orthotics included	Not Covered	Not Covered
Medical Supplies NYS & Federal Essential Health Benefit	Deduct/50% Coins	Not Covered
HEALTH & WELLNESS Incentive Programs NYS & Federal Essential Health Benefit	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months
<b>EMERGENCY SERVICES</b>		
<b>Emergency Condition</b>		
Facility – Emergency Room NYS & Federal Essential Health Benefit	Deduct/Coins	Covered same as INN
Physician’s Hospital Emergency Room Visit NYS & Federal Essential Health Benefit	Deduct/Coins	Covered same as INN
Prehospital Emergency Services/Transportation NYS & Federal Essential Health Benefit	Deduct/Coins	Covered same as INN
Freestanding Urgent Care Center Art 28 Facility NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Physician’s Freestanding Urgent Care Center (Art 28 Facility) NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Physician Urgent Care Office Visit NYS & Federal Essential Health Benefit	See office visit benefit	Not Covered
<b>VISION BENEFITS</b>		
Eye Exams Routine - Adults	Not Covered	Not Covered
Eyewear - Adults	Not Covered	Not Covered
Eye Exams Routine - Pediatric NYS & Federal Essential Health Benefit	Deduct/Coins 1 per 12 month period	Not Covered
Eyewear - Pediatric NYS & Federal Essential Health Benefit	Deduct/50% Coins  Lenses or Contacts once in any 12 month period Frames once in any 12 month period	Not Covered
<b>DENTAL BENEFITS</b>		
Adult Dental	Not Covered	Not Covered
Pediatric Dental - Emergency Care NYS & Federal Essential Health Benefit	Deduct/20% Coins	Not Covered
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	Deduct/20% Coins	Not Covered
Pediatric Dental - Routine NYS & Federal Essential Health Benefit	Deduct/20% Coins	Not Covered
Pediatric Dental - Endodontic NYS & Federal Essential Health Benefit	Deduct/50% Coins	Not Covered
Pediatric Dental - Prosthodontics NYS & Federal Essential Health Benefit	Deduct/50% Coins	Not Covered

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Benefit Type	In-Network	Out-of-Network
Pediatric Dental - Orthodontics NYS & Federal Essential Health Benefit	Deduct/50% Coins	Not Covered
<b>PRESCRIPTION DRUGS</b> Closed Formulary		
Generic or Tier 1/Tier 2/Tier 3 NYS & Federal Essential Health Benefit	Retail: 1 copay per 30 day supply Mail Order: Mail Order copay is 2.5 times retail for a 90 day supply	
Silver	Deductible Silver Select: \$10/45/90	Not Covered
Silver 200-250 FPL	Deductible Silver Subsidy #4: \$5/45/90	Not Covered
Silver 150-200 FPL	Deductible Silver Subsidy #5: \$5/45/90	Not Covered
Silver 100-150 FPL	Deductible Silver Subsidy #6: \$5/35/70	Not Covered
Bronze	Deductible Bronze Select: \$10/40%/50%	Not Covered
<b>WAITING PERIODS</b>	None	
<b>EXCLUSIONS</b>	Standard Exclusions apply	

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**2015 Individual Benefit Descriptions  
EXEC-4 (Rev.1) (Exclusive Provider Organization)**

**Tiered Network Plans Non-Standard  
Individual - Gold**

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
<b>PROVIDER NETWORK &amp; SERVICE AREA</b>			
Provider Network Counties - BCBS	BCBS 31 counties only		
Provider Network Counties - Univera	39 Counties: BCBS 31 plus Univera 8		
Bassett Service Area	Delaware; Herkimer; Otsego; Oneida		
CNY Service Area	Onondaga		
WNY Service Area	Erie		
<b>WHO IS COVERED</b>			
Type of Tiers – 4 Tier	Single - Subscriber or Child only 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family		
Dependent Coverage Federal Mandate	26 to end of month of birthday		
Dependents through age 29 State Mandate	Dependent Make Available		
Domestic Partner Coverage	Covered - standard		
<b>COST SHARING EXPENSES</b>			
Contract Year	Calendar Year		
Deductible · Single/ Family	Single: \$400 Family: \$800	Single: \$1,500 Family: \$3,000	Not Covered
4th Quarter Deductible Carry-Over Y/N	No	No	No
Copayment	\$25 PCP/ \$40 SPC	None	Not Covered
Coinsurance	None	20%	Not Covered
Annual Out-of-Pocket Maximum	Single: \$4000 Family: \$8000		Not Covered
Annual Benefit Maximum Federal Mandate	None		
Lifetime Benefit Maximum Federal Mandate	None		
<b>HOSPITAL INPATIENT SERVICES</b>			
Inpatient Hospital Services NYS & Federal Essential Health Benefit	Deduct/ \$500 copay per admission	Deduct/Coins	Not Covered
Mental Health Care Includes Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Substance Use Detoxification, Rehabilitation & Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Skilled Nursing Facility NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 200 days per contract year	Inpatient Hospital cost share applies. 200 days per contract year	Not Covered
Physical Rehabilitation includes habilitative services NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies.	Inpatient Hospital cost share applies.	Not Covered
Maternity Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies.	Inpatient Hospital cost share applies.	Not Covered
Maternity Care – Routine Newborn Nursery NYS & Federal Essential Health Benefit	Deduct/\$0 copay	Deduct/Coins	Not Covered
Internal Prosthetic (Implanted Devices) NYS & Federal Essential Health Benefit	Deduct/\$0 copay	Deduct/Coins	Not Covered
End of Life Care State Mandate NYS Essential Health Benefit	Inpatient Hospital cost share applies.	Inpatient Hospital cost share applies.	Not Covered

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**Tiered Network Plans Non-Standard  
Individual - Gold**

<b>Benefit Type</b>	<b>Preferred Network</b>	<b>Non-Preferred</b>	<b>Out-of-Network</b>
<b>Observation Stay NYS &amp; Federal Essential Health Benefit</b>	Deduct/\$100 copay	Deduct/Coins	Not Covered
<b>HOME CARE NYS &amp; Federal Essential Health Benefit</b>	Deduct/PCP Copay 40 visits per contract year	Deduct/Coins 40 visits per contract year	Not Covered
<b>HOSPICE CARE NYS &amp; Federal Essential Health Benefit</b>	Inpatient: Inpatient Hospital cost share applies. Hospice facility or Home: Deduct/ PCP copay per visit 210 days per year, 5 family bereavement visits	Inpatient: Deduct/Coins Hospice facility or Home: Deduct/Coins 210 days per year, 5 family bereavement visits	Not Covered
<b>HOSPITAL OUTPATIENT SERVICES</b>			
<b>Surgical Care including Surgicenters &amp; Freestanding Facilities NYS &amp; Federal Essential Health Benefit</b>	Deduct/ \$100 Copay	Deduct/Coins	Not Covered
<b>Pre-admission/Pre-Operative Testing NYS &amp; Federal Essential Health Benefit</b>	Deduct/ \$0 Copay	Deduct/Coins	Not Covered
<b>Diagnostic &amp; Routine X-ray NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>Advanced Imaging Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>Diagnostic &amp; Routine Laboratory and Pathology NYS &amp; Federal Essential Health Benefit</b>	Deduct/PCP Copay	Deduct/Coins	Not Covered
<b>Radiation Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>Chemotherapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/PCP Copay	Deduct/Coins	Not Covered
<b>Infusion Therapy NYS Essential Health Benefit</b>	Deduct/PCP Copay	Deduct/Coins	Not Covered
<b>Dialysis (all forms) NYS &amp; Federal Essential Health Benefit</b>	Deduct/PCP Copay	Deduct/Coins	<b>Not covered except Out of Area only:</b> Deduct/Coins
<b>Mental Health Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay Unlimited visits	Deduct/Coins Unlimited visits	Not Covered
<b>Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit</b>	Deduct/Specialist Copay Limit of 680 hours per contract year	Deduct/Coins Limit of 680 hours per contract year	Not Covered
<b>Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay 60 visits per condition per lifetime	Deduct/Coins 60 visits per condition per lifetime	Not Covered
<b>Pulmonary Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>Cardiac Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>PHYSICIAN SERVICES</b>			
<b>Inpatient Hospital Surgery NYS Essential Health Benefit</b>	Deduct/Coins	Deduct/Coins	Not Covered
<b>Office Surgery NYS Essential Health Benefit</b>	Deduct/ PCP/Specialist	Deduct/Coins	Not Covered
<b>Anesthesia Includes IP, OP, OV and maternity</b>	Deduct/Coins	Deduct/Coins	Not Covered
<b>Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay 60 visits per condition per lifetime	Deduct/Coins 60 visits per condition per lifetime	Not Covered

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<b>Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay 60 visits per condition per lifetime	Deduct/Coins 60 visits per condition per lifetime	Not Covered
<b>Pulmonary Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>Cardiac Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>Additional Surgical Opinion NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Second Medical Opinion for Cancer NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Maternity Care: Normal, Complications &amp; Termination. NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Deduct/Coins	Not Covered
<b>Prenatal Care HCR Preventive Service</b>	Covered in full	Covered in full	Not Covered
<b>In-Hospital Physician Visits NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Deduct/Coins	Not Covered
<b>PHYSICIAN OFFICE - OTHER SERVICES</b>			
<b>Diagnostic &amp; Routine Laboratory and Pathology NYS &amp; Federal Essential Health Benefit</b>	Deduct/PCP Copay	Deduct/Coins	Not Covered
<b>Diagnostic &amp; Routine X-ray NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Advanced Imaging Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Radiation Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Chemotherapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay	Deduct/Coins	Not Covered
<b>Infusion Therapy NYS Essential Health Benefit</b>	Deduct/ PCP copay	Deduct/Coins	Not Covered
<b>Dialysis (all forms) NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay	Deduct/Coins	Not covered except Out of Area only: Deduct/ PCP Copay per visit 40 visits per calendar year
<b>Mental Health Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay Unlimited visits	Deduct/Coins Unlimited visits	Not Covered
<b>Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit</b>	Deduct/Specialist Copay Limit of 680 hours per contract year	Deduct/Coins Limit of 680 hours per contract year	Not Covered
<b>Substance Use Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay Excludes family therapy.	Deduct/Coins Excludes family therapy.	Not Covered
<b>Office Visits - Diagnostic NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
<b>Medications Administered in Office NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
<b>Hearing Evaluations Diagnostic NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Chiropractic Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist copay	Deduct/Coins	Not Covered
<b>Office &amp; Outpatient Consultations NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
<b>Allergy Testing NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered

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Individual - Gold**

<b>Benefit Type</b>	<b>Preferred Network</b>	<b>Non-Preferred</b>	<b>Out-of-Network</b>
<b>Allergy Treatment Includes Serum and Injections NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
<b>Hearing Evaluations Routine NYS Essential Health Benefit</b>	Deduct/ Specialist copay	Deduct/Coins	Not Covered
<b>Hearing Aids NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins Single purchase once every 3 years	Deduct/50% Coins Single purchase once every 3 years	Not Covered
<b>Cochlear Implants</b>	Deduct/50% Coins One Per Ear Per Time Covered	Deduct/50% Coins One Per Ear Per Time Covered	Not Covered
<b>PREVENTIVE SERVICES Outpatient Facility &amp; Professional Provider</b>			
<b>Adult Physical Examinations Federal HCR Preventive Service NYS &amp; Federal Essential Health Benefit</b>	Covered in full 1 per contract year	Covered in full 1 per contract year	Not Covered
<b>Adult Immunizations Federal HCR Preventive Service NYS Essential Health Benefit Federal Essential Health Benefit</b>	Covered in full	Covered in full	Not Covered
<b>Well Child Visits and Immunizations Federal HCR Preventive Service NYS &amp; Federal Essential Health Benefit</b>	Covered in full	Covered in full	Not Covered
<b>Routine Gynecological Exams Federal HCR Preventive Service NYS &amp; Federal Essential Health Benefit</b>	Covered in full	Covered in full	Not Covered
<b>Cervical Cytology Preventive only Federal HCR Preventive Service NYS &amp; Federal Essential Health Benefit</b>	Covered in full	Covered in full	Not Covered
<b>Prostate Cancer Screenings Federal HCR Preventive Service NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
<b>Mammogram Screening Federal HCR Preventive Service NYS &amp; Federal Essential Health Benefit</b>	Covered in full 1 per contract year	Covered in full 1 per contract year	Not Covered
<b>Bone Density Testing Federal HCR Preventive Service NYS &amp; Federal Essential Health Benefit</b>	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Covered in full when HCR Preventive Deduct/Coins	Not Covered
<b>Colonoscopy Screening Federal HCR Preventive Service NYS &amp; Federal Essential Health Benefit</b>	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Covered in full when HCR Preventive Deduct/Coins	Not Covered
<b>Family Planning HCR Preventive Service</b>	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Covered in full when HCR Preventive Deduct/Coins	Not Covered
<b>ADDITIONAL BENEFITS</b>			
<b>Treatment of Diabetes Insulin &amp; Supplies NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay	Deduct/Coins	Not Covered
<b>Diabetic Education NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay	Deduct/Coins	Not Covered
<b>Diabetic Equipment NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay	Deduct/Coins	Not Covered
<b>Autism Assistive Communication Devices (ACD) State Mandate NYS Essential Health Benefit</b>	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>Autologous Blood Banking NYS Essential Health Benefit</b>	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>Durable Medical Equipment (DME) NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins	Deduct/50% Coins	Not Covered

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions  
EXEC-4 (Rev.1) (Exclusive Provider Organization)**

**Tiered Network Plans Non-Standard  
Individual - Gold**

<b>Benefit Type</b>	<b>Preferred Network</b>	<b>Non-Preferred</b>	<b>Out-of-Network</b>
<b>External Prosthetics NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins 1 external prosthetic device per limb per lifetime	Deduct/50% Coins 1 external prosthetic device per limb per lifetime	Not Covered
<b>Orthotics Foot orthotics included</b>	Not Covered	Not Covered	Not Covered
<b>Medical Supplies NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>HEALTH &amp; WELLNESS Incentive Programs NYS &amp; Federal Essential Health Benefit</b>	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months
<b>EMERGENCY SERVICES Emergency Condition</b>			
<b>Facility – Emergency Room NYS &amp; Federal Essential Health Benefit</b>	Deduct/\$100 copay	Deduct/\$100 copay	Deduct/\$100 copay
<b>Physician’s Hospital Emergency Room Visit NYS &amp; Federal Essential Health Benefit</b>	Deduct/\$0 copay	Deduct/\$0 copay	Deduct/\$0 copay
<b>Prehospital Emergency Services/Transportation NYS &amp; Federal Essential Health Benefit</b>	Deduct/\$100 copay	Deduct/\$100 copay	Deduct/\$100 copay
<b>Freestanding Urgent Care Center Art 28 Facility NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>Physician’s Freestanding Urgent Care Center (Art 28 Facility) NYS &amp; Federal Essential Health Benefit</b>	Deduct/\$0 copay	Deduct/Coins	Not Covered
<b>Physician Urgent Care Office Visit NYS &amp; Federal Essential Health Benefit</b>	See office visit benefit	See office visit benefit	Not Covered
<b>VISION BENEFITS</b>			
<b>Eye Exams Routine - Adults</b>	Not Covered	Not Covered	Not Covered
<b>Eyewear - Adults</b>	Not Covered	Not Covered	Not Covered
<b>Eye Exams Routine - Pediatric NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay 1 per 12 month period	Deduct/Coins 1 per 12 month period	Not Covered
<b>Eyewear - Pediatric NYS &amp; Federal Essential Health Benefit</b>	Deduct/50%Coins Lenses or Contacts once in any 12 month period Frames once in any 12 month period	Deduct/50%Coins Lenses or Contacts once in any 12 month period Frames once in any 12 month period	Not Covered
<b>DENTAL BENEFITS</b>			
<b>Adult Dental</b>	Not Covered	Not Covered	Not Covered
<b>Pediatric Dental - Emergency Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/20% Coins	Deduct/20% Coins	Not Covered
<b>Pediatric Dental - Preventive NYS &amp; Federal Essential Health Benefit</b>	Deduct/20% Coins	Deduct/20% Coins	Not Covered
<b>Pediatric Dental - Routine NYS &amp; Federal Essential Health Benefit</b>	Deduct/20% Coins	Deduct/20% Coins	Not Covered
<b>Pediatric Dental - Endodontic NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>Pediatric Dental - Prosthodontics NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>Pediatric Dental - Orthodontics NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>PRESCRIPTION DRUGS Closed Formulary</b>			

**Excellus Health Plan, Inc.**  
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**2015 Individual Benefit Descriptions**  
**EXEC-4 (Rev.1) (Exclusive Provider Organization)**

**Tiered Network Plans Non-Standard**  
**Individual - Gold**

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
<b>Generic or Tier 1/Tier 2/Tier 3 NYS &amp; Federal Essential Health Benefit</b>	Retail: 1 copay per 30 day supply Mail Order: Mail Order copay is 2.5 times retail for a 90 day supply	Retail: 1 copay per 30 day supply Mail Order: Mail Order copay is 2.5 times retail for a 90 day supply	
<b>Gold</b>	Copay: \$5 /\$35/\$70	Copay: \$5 /\$35/\$70	Not Covered
<b>WAITING PERIODS</b>	None		
<b>EXCLUSIONS</b>	Standard Exclusions apply		

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Effective Date: January 1, 2015  
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**2015 Individual Benefit Descriptions**

EXEC-4 (Rev.1), EXER-1 (Rev.1) [no Pediatric Dental]

**Tiered Network Plans Non-Standard  
Individual - Silver**

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
<b>PROVIDER NETWORK &amp; SERVICE AREA</b>			
Provider Network Counties - BCBS	BCBS 31 counties only		
Bassett Service Area	Delaware; Herkimer; Otsego; Oneida		
<b>WHO IS COVERED</b>			
Type of Tiers – 4 Tier	Single - Subscriber or Child only 2 Person - Subscriber & Spouse Family no spouse - Subscriber & Child(ren) Family		
Dependent Coverage Federal Mandate	26 to end of month of birthday		
Dependents through age 29 State Mandate	Dependent Make Available		
Domestic Partner Coverage	Covered - standard		
<b>COST SHARING EXPENSES</b>			
Contract Year	Calendar Year		
Deductible - Single/ Family	Silver: \$[1,250] Silver CSR: \$[0; 250; 1,250] Family = 2X single	Silver: \$[3,750] Silver CSR: \$[250; 750; 3,750] Family = 2X single	Not Covered
4th Quarter Deductible Carry-Over Y/N	No	No	No
Copayment	Silver: \$[30] PCP/ \$[50] SPC Silver CSR: \$[5 PCP/10 SPC; 15 PCP/25 SPC; 30 PCP/50 SPC]	None	Not Covered
Coinsurance	None	Silver Select: 30% Silver CSR: %[10, 20, 30]	Not Covered
Annual Out-of-Pocket Maximum	Silver: \$[6,350] Silver CSR: \$[2000; 2000; 4,250] Family = 2X single		Not Covered
Annual Benefit Maximum Federal Mandate	None		
Lifetime Benefit Maximum Federal Mandate	None		
<b>HOSPITAL INPATIENT SERVICES</b>			
Inpatient Hospital Services NYS & Federal Essential Health Benefit	Per Admission: Deduct/ \$[1,250] copay CSR : Deduct/ \$[100; 250; 1,250] copay	Deduct/Coins	Not Covered
Mental Health Care Includes Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Substance Use Detoxification, Rehabilitation & Residential Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. Unlimited days	Inpatient Hospital cost share applies. Unlimited days	Not Covered
Skilled Nursing Facility NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 200 days per contract year	Inpatient Hospital cost share applies. 200 days per contract year	Not Covered
Physical Rehabilitation includes habilitative services NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies.	Inpatient Hospital cost share applies.	Not Covered
Maternity Care NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies.	Inpatient Hospital cost share applies.	Not Covered
Maternity Care – Routine Newborn Nursery NYS & Federal Essential Health Benefit	Deduct/\$0 copay	Deduct/Coins	Not Covered
Internal Prosthetic (Implanted Devices) NYS & Federal Essential Health Benefit	Deduct/\$0 copay	Deduct/Coins	Not Covered

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**2015 Individual Benefit Descriptions**

EXEC-4 (Rev.1), EXER-1 (Rev.1) [no Pediatric Dental]

**Tiered Network Plans Non-Standard  
Individual - Silver**

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
End of Life Care State Mandate NYS Essential Health Benefit	Inpatient Hospital cost share applies.	Inpatient Hospital cost share applies.	Not Covered
Observation Stay NYS & Federal Essential Health Benefit	Deduct/ \$[250] copay CSR : Deduct/ \$[25; 75; 250] copay	Deduct/Coins	Not Covered
HOME CARE NYS & Federal Essential Health Benefit	Deduct/PCP Copay 40 visits per contract year	Deduct/Coins 40 visits per contract year	Not Covered
HOSPICE CARE NYS & Federal Essential Health Benefit	Inpatient: Inpatient Hospital cost share applies. Hospice facility or Home: Deduct/ PCP copay per visit 210 days per year, 5 family bereavement visits	Inpatient: Deduct/Coins Hospice facility or Home: Deduct/Coins 210 days per year, 5 family bereavement visits	Not Covered
<b>HOSPITAL OUTPATIENT SERVICES</b>			
Surgical Care including Surgicenters & Freestanding Facilities NYS & Federal Essential Health Benefit	Deduct/ \$[250] copay CSR : Deduct/ \$[25; 75; 250] copay	Deduct/Coins	Not Covered
Pre-admission/Pre-Operative Testing NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	Deduct/Coins	Not Covered
Diagnostic & Routine X-ray NYS & Federal Essential Health Benefit	Deduct/Specialist Copay	Deduct/Coins	Not Covered
Advanced Imaging Services NYS & Federal Essential Health Benefit	Deduct/Specialist Copay	Deduct/Coins	Not Covered
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	Deduct/PCP Copay	Deduct/Coins	Not Covered
Radiation Therapy NYS & Federal Essential Health Benefit	Deduct/Specialist Copay	Deduct/Coins	Not Covered
Chemotherapy NYS & Federal Essential Health Benefit	Deduct/PCP Copay	Deduct/Coins	Not Covered
Infusion Therapy NYS Essential Health Benefit	Deduct/PCP Copay	Deduct/Coins	Not Covered
Dialysis (all forms) NYS & Federal Essential Health Benefit	Deduct/PCP Copay	Deduct/Coins	<b>Not covered except Out of Area only:</b> Deduct/Coins
Mental Health Care NYS & Federal Essential Health Benefit	Deduct/Specialist Copay Unlimited visits	Deduct/Coins Unlimited visits	Not Covered
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	Deduct/Specialist Copay Limit of 680 hours per contract year	Deduct/Coins Limit of 680 hours per contract year	Not Covered
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Specialist Copay 60 visits per condition per lifetime	Deduct/Coins 60 visits per condition per lifetime	Not Covered
Pulmonary Rehabilitation NYS & Federal Essential Health Benefit	Deduct/Specialist Copay	Deduct/Coins	Not Covered
Cardiac Rehabilitation NYS & Federal Essential Health Benefit	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>PHYSICIAN SERVICES</b>			
Inpatient Hospital Surgery NYS Essential Health Benefit	Deduct/Coins	Deduct/Coins	Not Covered
Office Surgery NYS Essential Health Benefit	Deduct/ PCP/Specialist	Deduct/Coins	Not Covered
Anesthesia Includes IP, OP, OV and maternity	Deduct/Coins	Deduct/Coins	Not Covered

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**

EXEC-4 (Rev.1), EXER-1 (Rev.1) [no Pediatric Dental]

Tiered Network Plans Non-Standard  
Individual - Silver

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
<b>Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay 60 visits per condition per lifetime	Deduct/Coins 60 visits per condition per lifetime	Not Covered
<b>Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay 60 visits per condition per lifetime	Deduct/Coins 60 visits per condition per lifetime	Not Covered
<b>Pulmonary Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>Cardiac Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay	Deduct/Coins	Not Covered
<b>Additional Surgical Opinion NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Second Medical Opinion for Cancer NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Maternity Care: Normal, Complications &amp; Termination. NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Deduct/Coins	Not Covered
<b>Prenatal Care HCR Preventive Service</b>	Covered in full	Covered in full	Not Covered
<b>In-Hospital Physician Visits NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Deduct/Coins	Not Covered
<b>PHYSICIAN OFFICE - OTHER SERVICES</b>			
<b>Diagnostic &amp; Routine Laboratory and Pathology NYS &amp; Federal Essential Health Benefit</b>	Deduct/PCP Copay	Deduct/Coins	Not Covered
<b>Diagnostic &amp; Routine X-ray NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Advanced Imaging Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Radiation Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Chemotherapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay	Deduct/Coins	Not Covered
<b>Infusion Therapy NYS Essential Health Benefit</b>	Deduct/ PCP copay	Deduct/Coins	Not Covered
<b>Dialysis (all forms) NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay	Deduct/Coins	Not covered except Out of Area only: Deduct/ PCP Copay per visit
<b>Mental Health Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay Unlimited visits	Deduct/Coins Unlimited visits	Not Covered
<b>Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit</b>	Deduct/Specialist Copay Limit of 680 hours per contract year	Deduct/Coins Limit of 680 hours per contract year	Not Covered
<b>Substance Use Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay Excludes family therapy.	Deduct/Coins Excludes family therapy.	Not Covered
<b>Office Visits - Diagnostic NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
<b>Medications Administered in Office NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
<b>Hearing Evaluations Diagnostic NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
<b>Chiropractic Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/ Specialist copay	Deduct/Coins	Not Covered

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**2015 Individual Benefit Descriptions**

EXEC-4 (Rev.1), EXER-1 (Rev.1) [no Pediatric Dental]

Tiered Network Plans Non-Standard  
Individual - Silver

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
Office & Outpatient Consultations NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
Allergy Testing NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
Allergy Treatment Includes Serum and Injections NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
Hearing Evaluations Routine NYS Essential Health Benefit	Deduct/ Specialist copay	Deduct/Coins	Not Covered
Hearing Aids NYS & Federal Essential Health Benefit	Deduct/50% Coins Single purchase once every 3 years	Deduct/50% Coins Single purchase once every 3 years	Not Covered
Cochlear Implants	Deduct/50% Coins One Per Ear Per Time Covered	Deduct/50% Coins One Per Ear Per Time Covered	Not Covered
<b>PREVENTIVE SERVICES</b> Outpatient Facility & Professional Provider			
Adult Physical Examinations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Covered in full 1 per contract year	Not Covered
Adult Immunizations Federal HCR Preventive Service NYS Essential Health Benefit Federal Essential Health Benefit	Covered in full	Covered in full	Not Covered
Well Child Visits and Immunizations Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Covered in full	Not Covered
Routine Gynecological Exams Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Covered in full	Not Covered
Cervical Cytology Preventive only Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Covered in full	Not Covered
Prostate Cancer Screenings Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
Mammogram Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full 1 per contract year	Covered in full 1 per contract year	Not Covered
Bone Density Testing Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Covered in full when HCR Preventive Deduct/Coins	Not Covered
Colonoscopy Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Covered in full when HCR Preventive Deduct/Coins	Not Covered
Family Planning HCR Preventive Service	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Covered in full when HCR Preventive Deduct/Coins	Not Covered
<b>ADDITIONAL BENEFITS</b>			
Treatment of Diabetes Insulin & Supplies NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Deduct/Coins	Not Covered
Diabetic Education NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Deduct/Coins	Not Covered
Diabetic Equipment NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Deduct/Coins	Not Covered
Autism Assistive Communication Devices (ACD) State Mandate NYS Essential Health Benefit	Deduct/Specialist Copay	Deduct/Coins	Not Covered

**Excellus Health Plan, Inc.**  
Excellus BlueCross BlueShield

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**2015 Individual Benefit Descriptions**

EXEC-4 (Rev.1), EXER-1 (Rev.1) [no Pediatric Dental]

**Tiered Network Plans Non-Standard  
Individual - Silver**

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
<b>Autologous Blood Banking</b> NYS Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>Durable Medical Equipment (DME)</b> NYS & Federal Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>External Prosthetics</b> NYS & Federal Essential Health Benefit	Deduct/50% Coins 1 external prosthetic device per limb per lifetime	Deduct/50% Coins 1 external prosthetic device per limb per lifetime	Not Covered
<b>Orthotics</b> Foot orthotics included	Not Covered	Not Covered	Not Covered
<b>Medical Supplies</b> NYS & Federal Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>HEALTH &amp; WELLNESS</b> <b>Incentive Programs</b> NYS & Federal Essential Health Benefit	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months
<b>EMERGENCY SERVICES</b> Emergency Condition			
<b>Facility – Emergency Room</b> NYS & Federal Essential Health Benefit	Deduct/ \$[250] copay CSR : Deduct/ \$[25; 75; 250] copay	Deduct/ \$[250] copay CSR : Deduct/ \$[25; 75; 250] copay	Deduct/ \$[250] copay CSR : Deduct/ \$[25; 75; 250] copay
<b>Physician’s Hospital Emergency Room Visit</b> NYS & Federal Essential Health Benefit	Deduct/\$0 copay	Deduct/\$0 copay	Deduct/\$0 copay
<b>Prehospital Emergency Services/Transportation</b> NYS & Federal Essential Health Benefit	Deduct/ \$[250] copay CSR : Deduct/ \$[25; 75; 250] copay	Deduct/ \$[250] copay CSR : Deduct/ \$[25; 75; 250] copay	Deduct/ \$[250] copay CSR : Deduct/ \$[25; 75; 250] copay
<b>Freestanding Urgent Care Center</b> <b>Art 28 Facility</b> NYS & Federal Essential Health Benefit	Deduct/Specialist Copay CSR : Deduct/ \$[10; 25; 50] copay	Deduct/Coins	Not Covered
<b>Physician’s Freestanding Urgent Care Center (Art 28 Facility)</b> NYS & Federal Essential Health Benefit	Deduct/\$0 copay	Deduct/Coins	Not Covered
<b>Physician Urgent Care Office Visit</b> NYS & Federal Essential Health Benefit	See office visit benefit	See office visit benefit	Not Covered
<b>VISION BENEFITS</b>			
<b>Eye Exams Routine - Adults</b>	Not Covered	Not Covered	Not Covered
<b>Eyewear - Adults</b>	Not Covered	Not Covered	Not Covered
<b>Eye Exams Routine - Pediatric</b> NYS & Federal Essential Health Benefit	Deduct/Specialist Copay 1 per 12 month period	Deduct/Coins 1 per 12 month period	Not Covered
<b>Eyewear - Pediatric</b> NYS & Federal Essential Health Benefit	Deduct/50%Coins Lenses or Contacts once in any 12 month period Frames once in any 12 month period	Deduct/50%Coins Lenses or Contacts once in any 12 month period Frames once in any 12 month period	Not Covered
<b>DENTAL BENEFITS</b>			
<b>Adult Dental</b>	Not Covered	Not Covered	Not Covered
<b>Pediatric Dental - Emergency Care</b> NYS & Federal Essential Health Benefit	Deduct/20% Coins	Deduct/20% Coins	Not Covered
<b>Pediatric Dental - Preventive</b> NYS & Federal Essential Health Benefit	Deduct/20% Coins	Deduct/20% Coins	Not Covered
<b>Pediatric Dental - Routine</b> NYS & Federal Essential Health Benefit	Deduct/20% Coins	Deduct/20% Coins	Not Covered

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**Tiered Network Plans Non-Standard  
Individual - Silver**

<b>Benefit Type</b>	<b>Preferred Network</b>	<b>Non-Preferred</b>	<b>Out-of-Network</b>
<b>Pediatric Dental - Endodontic NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>Pediatric Dental - Prosthodontics NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>Pediatric Dental - Orthodontics NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>PRESCRIPTION DRUGS Closed Formulary</b>			
<b>Generic or Tier 1/Tier 2/Tier 3 NYS &amp; Federal Essential Health Benefit</b>	Retail: 1 copay per 30 day supply Mail Order: Mail Order copay is 2.5 times retail for a 90 day supply		
<b>Silver</b>	\$10/\$35/\$70 No Deductible	\$10/\$35/\$70 No Deductible	Not Covered
<b>Silver 200-250 FPL</b>	\$10/\$35/\$70 No Deductible	\$10/\$35/\$70 No Deductible	Not Covered
<b>Silver 150-200 FPL</b>	\$5/\$25/\$50 No Deductible	\$5/\$25/\$50 No Deductible	Not Covered
<b>Silver 100-150 FPL</b>	\$5/\$25/\$50 No Deductible	\$5/\$25/\$50 No Deductible	Not Covered
<b>Native American 300 FPL</b>	\$0 all tiers	N/A	Not Covered
<b>WAITING PERIODS</b>	None		
<b>EXCLUSIONS</b>	Standard Exclusions apply		

**Excelsus Health Plan, Inc.**  
Excelsus BlueCross BlueShield

Effective Date: January 1, 2015  
Community Rated

**2015 Individual Benefit Descriptions**

EXER-1 (Rev.1)  
Dependent Coverage through age 29

Benefit Type

**WHO IS COVERED**

Dependents through age 29  
State Mandate

Dependent Make Available

**Schedule of Commissions**

## SECTION A – OUTLINE OF COMMISSIONABLE AND NON-COMMISSIONABLE PRODUCTS

### 1. **General**

Agent/Broker commissions are limited to fully insured Excellus Health Plan group business purchasing the products listed below. Agent/Broker compensation, however, is based on combined sales under this and any other Schedule A to the Agent/Broker Agreement. This program excludes all: Medicare, Medicaid, Family Health Plus and Child Health Plus products.

If the group falls below the minimum participation requirement, no further commissions will be paid until the minimum participation is restored for that group.

As required by 11 NYCRR 52.42 (e), total commissions payable for HMO products under Section A below are subject to an aggregate maximum of 4% of the approved premium for the contract sold.

### 2. **Commissionable Medical Products**

#### A. Large Group

- (1) [HealthyBlue High Deductible Health Plan; ActiveUnivera High Deductible Health Plan]
- (2) [BluePPO HSA Options 1-4; UniveraPPO HSA Options 1-4]
- (3) [SimplyBlue High Deductible Health Plan; valUcare High Deductible Health Plan]
- (4) [HealthyBlue Copay Plan, SimplyBlue Copay Plan; ActiveUnivera Copay Plan, valUcare Copay Plan]
- (5) [HealthyBlue Copay/Deductible Plan, SimplyBlue Copay/Deductible Plan; ActiveUnivera Copay/Deductible Plan, valUcare Copay/Deductible Plan]
- (6) [Excellus BluePPO; UniveraPPO]
- (7) [Blue Point 3; Univera POS Select]
- (8) Blue Preferred PPO
- (9) Excellus BlueEPO
- (10) Blue Point 2]
- (11) [Classic Blue Traditional, Classic Blue Comprehensive, Classic Blue Secure; Classic Univera Traditional, Classic Univera Comprehensive]
- (12) [Blue Choice/HMO Blue \$25 and \$30]

#### B. Small Group

- (1) Off- SHOP
  - i. [SimplyBlue+ PPO, valUcare+ PPO]
  - ii. Healthy New York
- (2) SHOP
  - i. [SimplyBlue+ PPO, valUcare+ PPO]

#### C. Individual

- (1) Off Exchange
  - i. [ExchangeBlueEPO, ExchangeUniveraEPO]
  - ii. [ExchangeBassettEPO]
- (2) On Exchange
  - i. [ExchangeBlueEPO, ExchangeUniveraEPO]
  - ii. [ExchangeBassettEPO]

### 3. **Commissionable Dental Products**

- A. [Dental Blue Options; Univera Dental Select]
- B. [Dental Blue Classic; Univera Dental Traditions]
- C. Smile Saver (Growth only)
- D. Dental Blue PPO (Growth only)
- E. Dental Options I or II (Growth only)
- F. Dental Schedule A, B or C (Growth only)
- G. Prime Blue Dental (Growth only)]

SECTION B – MEDICAL BUSINESS

1. **New Medical Business** is commission eligible for employer groups that have not offered Excellus Health Plan products for six months prior to the effective date of coverage.
2. **Existing Medical Business** commissions will be subject to a \$150,000 annual maximum per group, with the exception of exclusive business with effective dates on or after January 1, 2014.

3. **Commission Schedules**

- A. Small Group (includes HMO business): 4% of Paid Premium
- B. Large Group (excludes HMO business): % of Paid Premium as follows:

Cumulative YTD Paid Premium	Percent of Paid Premium
First \$500,000	4.5%
\$500,001 - \$1,000,000	4.0%
\$1,000,001 - \$1,500,000	3.5%
\$1,500,001 - \$2,000,000	2.5%
\$2,000,001-\$5,000,000	1.5%
\$5,000,001+	1.0%

- C. Individual Market: \$25.00 Per Contract Per Month (PCPM)

4. **Medical Business Override Program**

- A. New Medical Business Override

The New Medical Business Override will be calculated on a quarterly basis beginning 01/01/2014 and paid based on Agent/Broker's year-to-date achievement of new medical contract and new medical group minimum targets according to the schedule below.

Qualifying new medical contracts must originate from prospect medical clients only. Growth on existing clients is not eligible for New Medical Business Override commissions. Payments will be made on Large Group (non HMO) business only. RMSCO business will be included in the qualifying calculation.

New Medical Contracts	New Medical Group Minimum	Payment
100-249	Two	\$15,000
250-499	Two	\$30,000
500-999	Three	\$50,000
1,000-1,499	Four	\$100,000
1,500 or more	Five	\$150,000

**B. Medical Business Retention Override**

The Medical Business Retention Override will be calculated on a calendar year basis and paid based on Agent/Broker's achievement of net medical book of business retention targets according to the schedule below.

Book of business retention measurement will reflect the Agent/Broker's ending medical contract count compared to the starting medical contract count for the period. New medical business acquired during the period will be included in the retention calculation. Payments will be made on Large Group (non HMO) business only. RMSCO business will be included in the qualifying calculation.

<b>% of Medical Contracts Retained</b>	<b>Payment</b>	<b>Maximum Payment</b>
95.0%	0.50% of in force premium	\$50,000 per agency
98.0%	0.75% of in force premium	\$75,000 per agency

**SECTION C – DENTAL BUSINESS**

- New Dental Business** is commission eligible for employer groups that have not offered Excellus Health Plan dental products for six months prior to the effective date of coverage.

The New Dental Business commission scale will be applied to group business in [Dental Blue Options or Dental Blue Classic; Univera Dental Select or Univera Dental Traditions] plans for all Broker of Record Letters in effect on or after 01/01/2014.

<b>Annual Premium Paid by Group</b>	<b>Commission Percentage</b>
Up to \$20,000	12%
\$20,001-\$30,000	10%
\$30,001-\$40,000	8%
\$40,001-\$50,000	6%
\$50,001-\$100,000	5%
Greater than \$100,000	2%

- Growth on Existing Dental Business** will qualify for commission eligibility when the Agent/Broker increases dental enrollment within an existing employer by a minimum of one contract.

<b>Annual Premium Paid by Group</b>	<b>Commission Percentage</b>
Up to \$20,000	12%
\$20,001-\$30,000	10%
\$30,001-\$40,000	8%
\$40,001-\$50,000	6%
\$50,001-\$100,000	5%
Greater than \$100,000	2%

**Excellus Health Plan, Inc.**  
 Excellus BlueCross BlueShield; Univera Healthcare  
 Agent/Broker Commission Schedule  
 Effective Date: January 01, 2014  
 Community and Experience Rated  
**Rate Manual**

3. **New Dental Business Override** will be calculated quarterly beginning 01/01/2014 and paid based on Agent/Broker's year-to-date achievement of new dental contract and group minimum targets.

Qualifying new dental contracts must originate from prospect dental clients only. Growth on existing clients is not eligible for New Business Override commission payment. RMSCO business will be included in the qualifying calculation.

<b>New Dental Contracts</b>	<b>New Dental Group Minimum</b>	<b>Payment</b>
100-199	Two	\$2,000
200-299	Three	\$5,000
300-399	Four	\$10,000
400-499	Five	\$15,000
500 or more	Six	\$30,000

4. **Dental Business Retention Override** will be calculated on a calendar year basis and paid based on Agent/Broker's achievement of net dental book of business retention targets.

Book of Business retention measurement will reflect the Agent/Broker's ending dental contract count compared to the starting dental contract count. New dental business acquired during the period will be included in the retention calculation. RMSCO business will be included in the qualifying calculation.

<b>% of Dental Contracts Retained</b>	<b>Payment</b>	<b>Maximum Payment</b>
95.0%	3% of in force premium	\$20,000 per agency
98.0%	5% of in force premium	\$40,000 per agency

**Underwriting Guidelines**



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## **Medical Commercial Non-Medicare Underwriting Guidelines Applied on an Individual Level**

Policies Effective: January 1, 2014

Last Revised: April 3, 2014

A nonprofit independent licensee of the Blue Cross Blue Shield Association

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## Introduction

Commercial direct pay coverage is available on a guaranteed issue and guaranteed renewal basis to subscribers and dependents that meet the requirements as specified in applicable federal and state laws and regulations and the underwriting guidelines of Excellus BlueCross BlueShield. Throughout this document, Excellus BlueCross BlueShield will be referred to as the health plan. Outlined below are the standard criteria that the health plan will follow to qualify direct pay subscribers and dependents for commercial coverage.

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## Disclaimer

The health plan reserves the right to make exceptions to these guidelines for circumstances where the subscriber/dependent does meet all of the criteria in these guidelines and when the exception will not violate any laws/regulations or harm the community pool.

These guidelines are effective January 1, 2014, and replace all previous individual commercial guidelines in use.

**I. Effective date:**

Individuals can only enroll in a direct pay product during open enrollment each year unless a special enrollment event applies.

**II. Renewal date:**

The renewal date for direct pay rates and benefits is January 1<sup>st</sup> of each year.

**III. Rates**

Direct pay products are community rated. Direct pay rates must be filed with the New York State Department of Financial Services at least 90 days in advance of the date of the rate change. Notification of a rate change must be provided to the direct pay subscriber in accordance with applicable state and federal laws and regulations.

**IV. Subscriber Eligibility:**

Filed and approved direct pay products are available to any prospective direct pay subscriber subject to the following limitations:

1. The subscriber is 18 years of age or older (except for child only policies), is a citizen of the United States or is in the United States validly and lives or resides within the service area of the health plan and meets applicable state and federal eligibility requirements.
2. For Bassett products, must live or work in Herkimer, Otsego, Chenango and Oneida counties, and meet other standard requirements.
3. Catastrophic coverage is only offered on the New York State of Health and to individuals under the age of 30, unless otherwise permitted by state or federal law or regulation.
4. Child Only plans are only available for children up to the age of 21.
5. A member enrolled in Medicare is not eligible to purchase a direct pay product. These individuals may purchase a Medicare Supplemental or Medicare Advantage product as available in the member's county of residence.

**V. Dependent Eligibility:**

Dependents are eligible to enroll in accordance with the subscriber certificate and applicable state and federal eligibility requirements.

**VI. Special Enrollment**

Special enrollment on and off the New York State of Health is in accordance with the subscriber certificate and applicable state and federal requirements.

**VII. Changes in coverage:**

A direct pay subscriber may change coverage only at open enrollment unless one of the following conditions applies:

1. Loses eligibility for the current product (e.g. moves out of Bassett territory)
2. Individual is a Native American (on the New York State of Health only)
3. Certain special enrollment events occur

**VIII. Coverage under this Contract may be terminated as follows:**

Coverage under the contract can be terminated in accordance with the subscriber certificate and applicable state and federal requirements.

**Note:** For products offered on the New York State of Health, all of the above conditions will comply with applicable state and federal requirements.



**Medical Commercial Non-Medicare  
Underwriting Guidelines  
Applied on an Individual Level**

Policies Effective: January 1, 2014

Last Revised: April 3, 2014

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## Introduction

Commercial direct pay coverage is available on a guaranteed issue and guaranteed renewal basis to subscribers and dependents that meet the requirements as specified in applicable federal and state laws and regulations and the underwriting guidelines of Univera Healthcare. Throughout this document, Univera Healthcare will be referred to as the health plan. Outlined below are the standard criteria that the health plan will follow to qualify direct pay subscribers and dependents for commercial coverage.

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## Disclaimer

The health plan reserves the right to make exceptions to these guidelines for circumstances where the subscriber/dependent does meet all of the criteria in these guidelines and when the exception will not violate any laws/regulations or harm the community pool.

These guidelines are effective January 1, 2014, and replace all previous individual commercial guidelines in use.

**I. Effective date:**

Individuals can only enroll in a direct pay product during open enrollment each year unless a special enrollment event applies.

**II. Renewal date:**

The renewal date for direct pay rates and benefits is January 1<sup>st</sup> of each year.

**III. Rates**

Direct pay products are community rated. Direct pay rates must be filed with the New York State Department of Financial Services at least 90 days in advance of the date of the rate change. Notification of a rate change must be provided to the direct pay subscriber in accordance with applicable state and federal laws and regulations.

**IV. Subscriber Eligibility:**

Filed and approved direct pay products are available to any prospective direct pay subscriber subject to the following limitations:

1. The subscriber is 18 years of age or older (except for child only policies), is a citizen of the United States or is in the United States validly and lives or resides within the service area of the health plan and meets applicable state and federal eligibility requirements.
2. Catastrophic coverage is only offered on the New York State of Health and to individuals under the age of 30, unless otherwise permitted by state or federal law or regulation.
3. Child Only plans are only available for children up to the age of 21.
4. A member enrolled in Medicare is not eligible to purchase a direct pay product. These individuals may purchase a Medicare Supplemental or Medicare Advantage product as available in the member's county of residence.

**V. Dependent Eligibility:**

Dependents are eligible to enroll in accordance with the subscriber certificate and applicable state and federal eligibility requirements.

**VI. Special Enrollment**

Special enrollment on and off the New York State of Health is in accordance with the subscriber certificate and applicable state and federal requirements.

**VII. Changes in coverage:**

A direct pay subscriber may change coverage only at open enrollment unless one of the following conditions applies:

1. Loses eligibility for the current product
2. Individual is a Native American (on the New York State of Health only)
3. Certain special enrollment events occur

**VIII. Coverage under this Contract may be terminated as follows:**

Coverage under the contract can be terminated in accordance with the subscriber certificate and applicable state and federal requirements.

**Note:** For products offered on the New York State of Health, all of the above conditions will comply with applicable state and federal requirements.

**Expected Loss Ratio**

**Excellus Health Plan, Inc.**

Excellus BlueCross BlueShield / Univera Healthcare

**Effective Date: January 1, 2015**

**Community Rated**

<b>Expected Loss Ratio</b>
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Individual Pool      84.3%

## Rating Regions

**Excellus Health Plan, Inc.**

Excellus BlueCross BlueShield / Univera Healthcare

**Effective Date: January 1, 2015**

**Community Rated**

**Rating Regions**

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**Region 1 (Albany Area)**

Montgomery  
Fulton

**Region 2 (Buffalo Area)**

Allegany  
Cattaraugus  
Chautauqua  
Erie  
Genesee  
Niagara  
Orleans  
Wyoming

**Region 3 (Mid-Hudson Area)**

Delaware

**Region 5 (Rochester Area)**

Livingston  
Monroe  
Ontario  
Seneca  
Wayne  
Yates

**Region 6 (Syracuse Area)**

Broome  
Cayuga  
Chemung  
Cortland  
Onondaga  
Schuyler  
Steuben  
Tioga  
Tompkins

**Region 7 (Utica/Watertown Area)**

Chenango  
Clinton  
Essex  
Franklin  
Hamilton  
Herkimer  
Jefferson  
Lewis  
Madison  
Oneida  
Oswego  
Otsego  
St. Lawrence