

**Excellus Health Plans, Inc  
dba**

**Excellus BCBS, Univera Healthcare**

**Individual Market  
On-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-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-3 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Base 2015	78124NY0910002	204.82	409.63	348.19	583.73	NA

**Excellus Health Plan, Inc.**

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2015

Community Rated

**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-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-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-3 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Base 2015	78124NY0910002	253.85	507.71	431.55	723.49	NA

**Excellus Health Plan, Inc.**

Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2015

Community Rated

**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-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-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
<b><u>EXEC-3 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Base 2015	78124NY0910002	269.95	539.89	458.91	769.35	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)[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-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-3 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Base 2015	78124NY0910002	269.95	539.89	458.91	769.35	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-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-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-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
<b><u>EXEC-3 (Rev.1)[no Pediatric Dental]</u></b>						
Excellus BCBS Base 2015	78124NY0910002	269.95	539.89	458.91	769.35	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-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-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-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-3 (Rev.1)[no Pediatric Dental]</u></b>						
Univera Base 2015	78124NY0960002	262.40	524.81	446.09	747.86	NA

**Outline of Benefits**

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

Effective Date: January 1, 2015  
Community Rated

**2015 Individual On 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-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-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
<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-3 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Excellus BCBS Base 2015	78124NY0910002	Base	6600	0%	ded/coins	ded/coins	6600	ded/coins	To age 26

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

Effective Date: January 1, 2015  
Community Rated

**2015 Individual On 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-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-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-3 (Rev.1)[no Pediatric Dental]</u></b>									
<b>Exclusive Provider Organization Contract</b>									
Univera Base 2015	78124NY0960002	Base	6600	0%	ded/coins	ded/coins	6600	ded/coins	To age 26

**Excelsus Health Plan, Inc.**  
Excelsus 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);  
EXEC-3 (Rev.1) (Exclusive Provider Organization, Catastrophic Plan);  
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)	
Dependent Coverage	26 to end of month of birthday	
Federal Mandate		
Dependents through age 29	Dependent Make Available	
State Mandate		
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	None	
Federal Mandate		
Lifetime Benefit Maximum	None	
Federal Mandate		
<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

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NYS Benchmark Plan  
Individual

Benefit Type	In-Network	Out-of-Network
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
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	Platinum: \$[100] copay Gold: \$[150] Silver: \$[150] Silver CSR: \$[50; 75; 150]	Not Covered
HOME CARE NYS & Federal Essential Health Benefit	Deduct/ 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/ PCP copay per visit 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	Platinum: Deduct/ \$[100] copay Gold: Deduct/ \$[100] Silver: Deduct/ \$[100] Silver CSR: Deduct/ \$[25; 75; 100]	Not Covered
Pre-admission/Pre-Operative Testing NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	Not Covered
Diagnostic & Routine X-ray NYS & Federal Essential Health Benefit	Deduct/ 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	Specialist Copay	Not Covered
Advanced Imaging Services NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Not Covered
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Not Covered
Radiation Therapy NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit	Not Covered

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Individual

Benefit Type	In-Network	Out-of-Network
Chemotherapy NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit	Not Covered
Infusion Therapy NYS Essential Health Benefit	Deduct/ PCP Copay per visit	Not Covered
Dialysis (all forms) NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit	Not covered except Out of Area only: Deduct/ PCP Copay per visit
Mental Health Care NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit Unlimited visits	Not Covered
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	Deduct/ PCP Copay per visit Limit of 680 hours per contract year	Not Covered
Substance Use Services NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit 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	Platinum: \$[25] copay per visit Gold: \$[30] Silver: \$[30] Silver CSR: \$[15; 25; 30]	Not Covered
Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Platinum: \$[25] copay per visit Gold: \$[30] Silver: \$[30] Silver CSR: \$[15; 25; 30] 60 visits per condition per lifetime	Not Covered
Pulmonary Rehabilitation NYS & Federal Essential Health Benefit	Deduct/ PCP Copay per visit	Not Covered
Cardiac Rehabilitation NYS & Federal Essential Health Benefit	PCP Copay	Not Covered
<b>PHYSICIAN SERVICES</b>		
Inpatient Hospital Surgery NYS Essential Health Benefit	Platinum: \$[100] copay Gold: Deduct/ \$[100] Silver: Deduct/ \$[100] Silver CSR: Deduct/ \$[25; 75; 100]	Not Covered
Outpatient Hospital & Ambulatory Surgery NYS Essential Health Benefit	Platinum: \$[100] copay Gold: Deduct/ \$[100] Silver: Deduct/ \$[100] Silver CSR: Deduct/ \$[25; 75; 100]	Not Covered
Office Surgery NYS Essential Health Benefit	Deduct/ PCP/Specialist	Not Covered
Anesthesia Includes IP, OP, OV and maternity NYS & Federal Essential Health Benefit	Covered in Full, no Deductible	Not Covered
Covered Therapies - Rehabilitation Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	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

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Individual

Benefit Type	In-Network	Out-of-Network
<b>Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy 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 NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP Copay	Not Covered
<b>Cardiac Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP 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>	Platinum: \$[100] copay Gold: Deduct/ \$[100] Silver: Deduct/ \$[100] Silver CSR: Deduct/ \$[25; 75; 100]	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/ \$0 Copay	Not Covered
<b>PHYSICIAN OFFICE - OTHER SERVICES</b>		
<b>Diagnostic &amp; Routine Laboratory and Pathology NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Not Covered
<b>Diagnostic &amp; Routine X-ray NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/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/ PCP 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 10 visits per calendar yr
<b>Mental Health Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP copay Unlimited visits	Not Covered
<b>Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit</b>	Deduct/ PCP copay Limit of 680 hours per contract year	Not Covered

**Excellus Health Plan, Inc.**  
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EXER-2 (Rev.1) (Out of Network Rider)  
Platinum, Gold, & Silver  
NYS Benchmark Plan  
Individual

Benefit Type	In-Network	Out-of-Network
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>		
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

**Excellus Health Plan, Inc.**  
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EXER-2 (Rev.1) (Out of Network Rider)  
Platinum, Gold, & Silver  
NYS Benchmark Plan  
Individual

Benefit Type	In-Network	Out-of-Network
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/ PCP/Specialist Copay	Not Covered
Colonoscopy Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Not Covered
Family Planning HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Not Covered
<b>ADDITIONAL BENEFITS</b>		
Treatment of Diabetes Insulin & Supplies NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered
Diabetic Education NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered
Diabetic Equipment NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered
Autism Assistive Communication Devices (ACD) State Mandate NYS Essential Health Benefit	Deduct/ PCP copay	Not Covered
Autologous Blood Banking NYS Essential Health Benefit	Platinum: [10]% Coins Gold: Deduct/ [20]% Coins Silver: Deduct/ [30]% Coins Silver CSR: Deduct/ [5; 10; 25]% Coins	Not Covered
Durable Medical Equipment (DME) 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
External Prosthetics 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
Orthotics Foot orthotics included	Not Covered	Not Covered

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Platinum, Gold, & Silver  
NYS Benchmark Plan  
Individual

Benefit Type	In-Network	Out-of-Network
Medical Supplies 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
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>		
Facility – Emergency Room 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]
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	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]
Freestanding Urgent Care Center 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
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

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Individual

Benefit Type	In-Network	Out-of-Network
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	Not Covered	Not Covered
Preventive - Prophylaxis	Preventive cost share 1 per six months	Preventive cost share 1 per six months
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
Routine - Exams, Visits & Consults	Routine cost share 1 per six consecutive month period	Routine cost share 1 per six consecutive month period
Routine - Full Mouth X-rays	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
Routine - Bitewing X-rays	Routine cost share 1 per 6 to 12 months	Routine cost share 1 per 6 to 12 months
Routine - Panoramic X-ray	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
Routine - Other X-rays	Routine cost share	Routine cost share
Routine - Simple Extractions	Routine cost share	Routine cost share
Routine - Routine Surgery	Routine cost share	Routine cost share
Routine - Conscious Sedation	Routine cost share	Routine cost share
Routine - Restorations - Amalgam, Composite & Other Restorative Materials	Routine cost share	Routine cost share
Routine - Stainless Steel Crowns	Routine cost share	Routine cost share
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>		
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

**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);  
EXEC-3 (Rev.1) (Exclusive Provider Organization, Catastrophic Plan);  
EXER-2 (Rev.1) (Out of Network Rider)  
Platinum, Gold, & Silver  
NYS Benchmark Plan  
Individual

Benefit Type	In-Network	Out-of-Network
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
Catastrophic	Deduct/Coins	Not Covered
WAITING PERIODS	None	
EXCLUSIONS	Standard Exclusions apply	

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Excelsus BlueCross BlueShield

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EXEC-2 (Rev.1) (Exclusive Provider Organization Child Only);  
EXEC-3 (Rev.1) (Exclusive Provider Organization, Catastrophic Plan);  
EXER-2 (Rev.1) (Out of Network Rider)  
Bronze & Catastrophic Standard  
NYS Benchmark Plan  
Individual

Benefit Type	On Exchange	
	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)	
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 Catastrophic: \$6,600 Family = 2X single	Not Covered
4th Quarter Deductible Carry-Over Y/N	No	No
Copayment	Bronze: None Catastrophic: None	Not Covered
Coinsurance	Bronze: [50]% Catastrophic: [0]%	Not Covered
Annual Out-of-Pocket Maximum	Single: Bronze: \$[6,350] Catastrophic: \$[6,600] 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

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Bronze & Catastrophic Standard  
NYS Benchmark Plan  
Individual

Benefit Type	In-Network	On Exchange
		Out-of-Network
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
HOME CARE NYS & Federal Essential Health Benefit	<b>Bronze:</b> Deduct/Coins <b>Catastrophic:</b> 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/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

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EXER-2 (Rev.1) (Out of Network Rider)  
Bronze & Catastrophic Standard  
NYS Benchmark Plan  
Individual

Benefit Type	In-Network	On Exchange
		Out-of-Network
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
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

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Bronze & Catastrophic Standard  
NYS Benchmark Plan  
Individual

Benefit Type	On Exchange	
	In-Network	Out-of-Network
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 10 visits per calendar yr
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	Bronze: Deduct/Coins Catastrophic: 3 primary visits CIF, 4th & after Deduct/Coins	Not Covered

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Bronze & Catastrophic Standard  
NYS Benchmark Plan  
Individual

Benefit Type	On Exchange	
	In-Network	Out-of-Network
Medications Administered in Office NYS & Federal Essential Health Benefit	Bronze: Deduct/Coins Catastrophic: 3 primary visits CIF, 4th & after 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
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>		
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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Bronze & Catastrophic Standard  
NYS Benchmark Plan  
Individual

Benefit Type	On Exchange	
	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/Coins	Not Covered
<b>Colonoscopy Screening</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/Coins	Not Covered
<b>Family Planning</b> HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/Coins	Not Covered
<b>ADDITIONAL BENEFITS</b>		
<b>Treatment of Diabetes Insulin &amp; Supplies</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Diabetic Education</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Diabetic Equipment</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Autism Assistive Communication Devices (ACD)</b> State Mandate NYS Essential Health Benefit	Deduct/Coins	Not Covered
<b>Autologous Blood Banking</b> NYS Essential Health Benefit	Deduct/Coins	Not Covered
<b>Durable Medical Equipment (DME)</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<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>		
<b>Facility – Emergency Room</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Covered same as INN

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Bronze & Catastrophic Standard  
NYS Benchmark Plan  
Individual

Benefit Type	On Exchange	
	In-Network	Out-of-Network
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/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/Coins	Not Covered
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Preventive - Prophylaxis	Preventive cost share 1 per six months	Preventive cost share 1 per six months
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/Coins	Not Covered
Routine - Exams, Visits & Consults	Routine cost share 1 per six consecutive month period	Routine cost share 1 per six consecutive month period
Routine - Full Mouth X-rays	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months

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Bronze & Catastrophic Standard  
NYS Benchmark Plan  
Individual

Benefit Type	On Exchange	
	In-Network	Out-of-Network
Routine - Bitewing X-rays	Routine cost share 1 per 6 to 12 months	Routine cost share 1 per 6 to 12 months
Routine - Panoramic X-ray	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
Routine - Other X-rays	Routine cost share	Routine cost share
Routine - Simple Extractions	Routine cost share	Routine cost share
Routine - Routine Surgery	Routine cost share	Routine cost share
Routine - Conscious Sedation	Routine cost share	Routine cost share
Routine - Restorations - Amalgam, Composite & Other Restorative Materials	Routine cost share	Routine cost share
Routine - Stainless Steel Crowns	Routine cost share	Routine cost share
Pediatric Dental - Endodontic NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Pediatric Dental - Prosthodontics NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
Pediatric Dental - Orthodontics NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>PRESCRIPTION DRUGS</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
Catastrophic	Deduct/Coins	Not Covered
WAITING PERIODS	None	
EXCLUSIONS	Standard Exclusions apply	

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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
<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)	
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

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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
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
Observation Stay NYS & Federal Essential Health Benefit	\$75 copay	Not Covered
HOME CARE NYS & Federal Essential Health Benefit	<b>PCP Copay</b> 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	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

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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
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
Cardiac 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
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

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

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Community Rated

**2015 Individual Benefit Descriptions**

EXEC-1 (Rev.1) (Exclusive Provider Organization);  
EXEC-2 (Rev.1) (Exclusive Provider Organization Child Only);  
EXEC-3 (Rev.1) (Exclusive Provider Organization, Catastrophic Plan);  
EXER-2 (Rev.1) (Out of Network Rider)  
Copay Plan Non-Standard  
Individual - Platinum

Benefit Type	In-Network	Out-of-Network
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
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

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Copay Plan Non-Standard  
Individual - Platinum

Benefit Type	In-Network	Out-of-Network
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>		
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 NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive PCP/Specialist Copay	Not Covered

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Individual - Platinum

Benefit Type	In-Network	Out-of-Network
<b>ADDITIONAL BENEFITS</b>		
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
<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>		
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

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Individual - Platinum

Benefit Type	In-Network	Out-of-Network
<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
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	20% Coins	Not Covered
Preventive - Prophylaxis	Preventive cost share 1 per six months	Preventive cost share 1 per six months
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	20% Coins	Not Covered
Routine - Exams, Visits & Consults	Routine cost share 1 per six consecutive month period	Routine cost share 1 per six consecutive month period
Routine - Full Mouth X-rays	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
Routine - Bitewing X-rays	Routine cost share 1 per 6 to 12 months	Routine cost share 1 per 6 to 12 months
Routine - Panoramic X-ray	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
Routine - Other X-rays	Routine cost share	Routine cost share
Routine - Simple Extractions	Routine cost share	Routine cost share
Routine - Routine Surgery	Routine cost share	Routine cost share
Routine - Conscious Sedation	Routine cost share	Routine cost share
Routine - Restorations - Amalgam, Composite & Other Restorative Materials	Routine cost share	Routine cost share
Routine - Stainless Steel Crowns	Routine cost share	Routine cost share
Pediatric Dental - Endodontic NYS & Federal Essential Health Benefit	50% Coins	Not Covered

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Copay Plan Non-Standard  
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Benefit Type	In-Network	Out-of-Network
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>		
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: \$5 /\$25/\$50	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
Catastrophic	Deduct/Coins	Not Covered
<b>WAITING PERIODS</b>	None	
<b>EXCLUSIONS</b>	Standard Exclusions apply	

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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)	
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

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Benefit Type	In-Network	Out-of-Network
<b>Physical Rehabilitation</b> includes habilitative services NYS & Federal Essential Health Benefit	Inpatient Hospital cost share applies. 1 consecutive 60 day stay per condition per lifetime	Not Covered
<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>Internal Prosthetic (Implanted Devices)</b> NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	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	Deduct/\$250 copay	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	Deduct/ \$250 Copay	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/PCP Copay	Not Covered
<b>Radiation Therapy</b> NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Not Covered
<b>Chemotherapy</b> NYS & Federal Essential Health Benefit	Deduct/PCP Copay	Not Covered
<b>Infusion Therapy</b> NYS Essential Health Benefit	Deduct/PCP Copay	Not Covered
<b>Dialysis (all forms)</b> NYS & Federal Essential Health Benefit	Deduct/PCP Copay	Not covered except Out of Area only: Deduct/ PCP Copay per visit

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Benefit Type	In-Network	Out-of-Network
<b>Mental Health Care</b> NYS & Federal Essential Health Benefit	Deduct/Specialist Copay Unlimited visits	Not Covered
<b>Autism Applied Behavior Analysis</b> State Mandate NYS Essential Health Benefit	Deduct/Specialist Copay Limit of 680 hours per contract year	Not Covered
<b>Substance Use Services</b> NYS & Federal Essential Health Benefit	Deduct/Specialist Copay Unlimited visits. Covers 20 visits per calendar year for family therapy.	Not Covered
<b>Covered Therapies - Rehabilitation</b> Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Specialist Copay 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/Specialist Copay 60 visits per condition per lifetime	Not Covered
<b>Pulmonary Rehabilitation</b> NYS & Federal Essential Health Benefit	Deduct/Specialist Copay	Not Covered
<b>Cardiac Rehabilitation</b> NYS & Federal Essential Health Benefit	PCP Copay	Not Covered
<b>PHYSICIAN SERVICES</b>		
<b>Inpatient Hospital Surgery</b> NYS Essential Health Benefit	Deduct/Coins	Not Covered
<b>Outpatient Hospital &amp; Ambulatory Surgery</b> NYS Essential Health Benefit	Deduct/Coins	Not Covered
<b>Office Surgery</b> NYS Essential Health Benefit	Deduct/ PCP/Specialist	Not Covered
<b>Anesthesia</b> Includes IP, OP, OV and maternity NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Covered Therapies - Rehabilitation</b> Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Specialist Copay 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/Specialist Copay 60 visits per condition per lifetime	Not Covered
<b>Pulmonary Rehabilitation</b> NYS & Federal Essential Health Benefit	Deduct/Specialist Copay	Not Covered
<b>Cardiac Rehabilitation</b> NYS & Federal Essential Health Benefit	Deduct/Specialist Copay	Not Covered
<b>Additional Surgical Opinion</b> NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Not Covered
<b>Second Medical Opinion for Cancer</b> NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Not Covered
<b>Maternity Care: Normal, Complications &amp; Termination.</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered

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Benefit Type	In-Network	Out-of-Network
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/PCP Copay	Not Covered
Diagnostic & Routine X-ray NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Not Covered
Advanced Imaging Services NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Not Covered
Radiation Therapy NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Not Covered
Chemotherapy NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered
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 10 visits per calendar yr
Mental Health Care NYS & Federal Essential Health Benefit	Deduct/Specialist Copay Unlimited visits	Not Covered
Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit	Deduct/Specialist Copay Limit of 680 hours per contract year	Not Covered
Substance Use Services NYS & Federal Essential Health Benefit	Deduct/Specialist 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/ Specialist Copay	Not Covered
Hearing Evaluations Diagnostic NYS & Federal Essential Health Benefit	Deduct/ 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

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Benefit Type	In-Network	Out-of-Network
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	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>		
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/ PCP/Specialist Copay	Not Covered
Colonoscopy Screening Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Not Covered
Family Planning HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/ PCP/Specialist Copay	Not Covered
<b>ADDITIONAL BENEFITS</b>		
Treatment of Diabetes Insulin & Supplies NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered
Diabetic Education NYS & Federal Essential Health Benefit	Deduct/ PCP copay	Not Covered

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Benefit Type	In-Network	Out-of-Network
<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
<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>		
<b>Facility – Emergency Room</b> NYS & Federal Essential Health Benefit	Deduct/\$250 copay	Deduct/\$250 copay
<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	Deduct/\$250 copay	Deduct/\$250 copay
<b>Freestanding Urgent Care Center</b> Art 28 Facility NYS & Federal Essential Health Benefit	Deduct/Specialist Copay	Not Covered
<b>Physician’s Freestanding Urgent Care Center (Art 28 Facility)</b> NYS & Federal Essential Health Benefit	Deduct/ \$0 Copay	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/Specialist Copay 1 per 12 month period	Not Covered

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

Benefit Type	In-Network	Out-of-Network
<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	Not Covered
<b>DENTAL BENEFITS</b>		
<b>Adult Dental</b>	Not Covered	Not Covered
<b>Pediatric Dental - Emergency Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/20% Coins	Not Covered
<b>Pediatric Dental - Preventive NYS &amp; Federal Essential Health Benefit</b>	Deduct/20% Coins	Not Covered
<b>Preventive - Prophylaxis</b>	Preventive cost share 1 per six months	Preventive cost share 1 per six months
<b>Preventive - Topical Fluoride Application</b>	Preventive cost share 1 per six months	Preventive cost share 1 per six months
<b>Preventive - Sealants</b>	Preventive cost share	Preventive cost share
<b>Preventive - Space Maintainers</b>	Preventive cost share	Preventive cost share
<b>Pediatric Dental - Routine NYS &amp; Federal Essential Health Benefit</b>	Deduct/20% Coins	Not Covered
<b>Routine - Exams, Visits &amp; Consults</b>	Routine cost share 1 per six consecutive month period	Routine cost share 1 per six consecutive month period
<b>Routine - Full Mouth X-rays</b>	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
<b>Routine - Bitewing X-rays</b>	Routine cost share 1 per 6 to 12 months	Routine cost share 1 per 6 to 12 months
<b>Routine - Panoramic X-ray</b>	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
<b>Routine - Other X-rays</b>	Routine cost share	Routine cost share
<b>Routine - Simple Extractions</b>	Routine cost share	Routine cost share
<b>Routine - Routine Surgery</b>	Routine cost share	Routine cost share
<b>Routine - Conscious Sedation</b>	Routine cost share	Routine cost share
<b>Routine - Restorations - Amalgam, Composite &amp; Other Restorative Materials</b>	Routine cost share	Routine cost share
<b>Routine - Stainless Steel Crowns</b>	Routine cost share	Routine cost share
<b>Pediatric Dental - Endodontic NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins	Not Covered
<b>Pediatric Dental - Prosthodontics NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins	Not Covered
<b>Pediatric Dental - Orthodontics NYS &amp; Federal Essential Health Benefit</b>	Deduct/50% Coins	Not Covered
<b>PRESCRIPTION DRUGS</b>		

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Hybrid A Plans Non-Standard  
Individual - Gold**

Benefit Type	In-Network	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	
<b>Platinum</b>	Copay: \$10 /\$30/\$60	Not Covered
<b>Gold</b>	Copay: \$5 /\$35/\$70	Not Covered
<b>Silver</b>	Copay: \$10 /\$35/\$70	Not Covered
<b>Silver 200-250 FPL</b>	Copay: \$10 /\$35/\$70	Not Covered
<b>Silver 150-200 FPL</b>	Copay: \$9 /\$20/\$40	Not Covered
<b>Silver 100-150 FPL</b>	Copay: \$6/\$15/\$30	Not Covered
<b>Native American 300 FPL</b>	\$0 all tiers	Not Covered
<b>Bronze</b>	Deductible Copay: \$10 /\$35/\$70	Not Covered
<b>Catastrophic</b>	Deduct/Coins	Not Covered
<b>WAITING PERIODS</b>	None	
<b>EXCLUSIONS</b>	Standard Exclusions apply	

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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)	
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	

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Individual - [Silver; Bronze]

Benefit Type	In-Network	Out-of-Network
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
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	Specialist Copay	Not Covered
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	Specialist Copay	Not Covered

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Benefit Type	In-Network	Out-of-Network
<b>Advanced Imaging Services</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Diagnostic &amp; Routine Laboratory and Pathology</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
<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 Unlimited visits. Covers 20 visits per calendar year for family therapy.	Not Covered
<b>Covered Therapies - Rehabilitation</b> Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Covered Therapies - Habilitation</b> Only Physical, Speech, and Occupational Therapy NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Pulmonary Rehabilitation</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Cardiac Rehabilitation</b> NYS & Federal Essential Health Benefit	PCP Copay	Not Covered
<b>PHYSICIAN SERVICES</b>		
<b>Inpatient Hospital Surgery</b> NYS Essential Health Benefit	Deduct/Coins	Not Covered
<b>Outpatient Hospital &amp; Ambulatory Surgery</b> NYS Essential Health Benefit	Deduct/Coins	Not Covered
<b>Office Surgery</b> NYS Essential Health Benefit	Deduct/Coins	Not Covered
<b>Anesthesia</b> Includes IP, OP, OV and maternity NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<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

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Benefit Type	In-Network	Out-of-Network
<b>Covered Therapies - Habilitation Only Physical, Speech, and Occupational Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins 60 visits per condition per lifetime	Not Covered
<b>Pulmonary Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>Cardiac Rehabilitation NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>Additional Surgical Opinion NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>Second Medical Opinion for Cancer NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	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/Coins	Not Covered
<b>Diagnostic &amp; Routine X-ray NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>Advanced Imaging Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>Radiation Therapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>Chemotherapy NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>Infusion Therapy NYS Essential Health Benefit</b>	Deduct/Coins	Not Covered
<b>Dialysis (all forms) NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins	Not covered except Out of Area only: Deduct/ PCP Copay per visit 10 visits per calendar yr
<b>Mental Health Care NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins Unlimited visits	Not Covered
<b>Autism Applied Behavior Analysis State Mandate NYS Essential Health Benefit</b>	Deduct/Coins Limit of 680 hours per contract year	Not Covered
<b>Substance Use Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/Coins Excludes family therapy.	Not Covered

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Individual - [Silver; Bronze]

Benefit Type	In-Network	Out-of-Network
Office Visits - Diagnostic NYS & Federal Essential Health Benefit	Bronze: Deduct/Coins Catastrophic: 3 primary visits CIF, 4th & after Deduct/Coins	Not Covered
Medications Administered in Office NYS & Federal Essential Health Benefit	Bronze: Deduct/Coins Catastrophic: 3 primary visits CIF, 4th & after 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
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>		
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

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Individual - [Silver; Bronze]

Benefit Type	In-Network	Out-of-Network
<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/Coins	Not Covered
<b>Colonoscopy Screening</b> Federal HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/Coins	Not Covered
<b>Family Planning</b> HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full when HCR Preventive Deduct/Coins	Not Covered
<b>ADDITIONAL BENEFITS</b>		
<b>Treatment of Diabetes Insulin &amp; Supplies</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Diabetic Education</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Diabetic Equipment</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Not Covered
<b>Autism Assistive Communication Devices (ACD)</b> State Mandate NYS Essential Health Benefit	Deduct/Coins	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
<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>		
<b>Facility – Emergency Room</b> NYS & Federal Essential Health Benefit	Deduct/Coins	Covered same as INN

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Individual - [Silver; Bronze]

Benefit Type	In-Network	Out-of-Network
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
Preventive - Prophylaxis	Preventive cost share 1 per six months	Preventive cost share 1 per six months
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/20% Coins	Not Covered
Routine - Exams, Visits & Consults	Routine cost share 1 per six consecutive month period	Routine cost share 1 per six consecutive month period
Routine - Full Mouth X-rays	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
Routine - Bitewing X-rays	Routine cost share 1 per 6 to 12 months	Routine cost share 1 per 6 to 12 months

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Benefit Type	In-Network	Out-of-Network
Routine - Panoramic X-ray	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
Routine - Other X-rays	Routine cost share	Routine cost share
Routine - Simple Extractions	Routine cost share	Routine cost share
Routine - Routine Surgery	Routine cost share	Routine cost share
Routine - Conscious Sedation	Routine cost share	Routine cost share
Routine - Restorations - Amalgam, Composite & Other Restorative Materials	Routine cost share	Routine cost share
Routine - Stainless Steel Crowns	Routine cost share	Routine cost share
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>		
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	N/A	Not Covered
Gold	N/A	Not Covered
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
Native American 300 FPL	N/A	Not Covered
Bronze	Deductible Bronze Select: \$10/40%/50%	Not Covered
Catastrophic	N/A	Not Covered
<b>WAITING PERIODS</b>	None	
<b>EXCLUSIONS</b>	Standard Exclusions apply	

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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)		
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

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Individual - Gold

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
<b>Maternity Care – Routine Newborn Nursery NYS &amp; Federal Essential Health Benefit</b>	Deduct/\$0 copay	Deduct/Coins	Not Covered
<b>Internal Prosthetic (Implanted Devices) NYS &amp; Federal Essential Health Benefit</b>	Deduct/\$0 copay	Deduct/Coins	Not Covered
<b>End of Life Care State Mandate NYS Essential Health Benefit</b>	Inpatient Hospital cost share applies.	Inpatient Hospital cost share applies.	Not Covered
<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>Substance Use Services NYS &amp; Federal Essential Health Benefit</b>	Deduct/Specialist Copay Unlimited visits. Covers 20 visits per calendar year for family therapy.	Deduct/Coins Unlimited visits. Covers 20 visits per calendar year for family therapy.	Not Covered

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Individual - Gold

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>PHYSICIAN SERVICES</b>			
<b>Inpatient Hospital Surgery NYS Essential Health Benefit</b>	Deduct/Coins	Deduct/Coins	Not Covered
<b>Outpatient Hospital &amp; Ambulatory 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 NYS &amp; Federal Essential Health Benefit</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
<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 NYS &amp; Federal Essential Health Benefit</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

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Individual - Gold

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
<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 10 visits per calendar yr
<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>Eye Exams - Diagnostic NYS &amp; Federal Essential Health Benefit</b>	Deduct/ 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
<b>Allergy Treatment Includes Serum and Injections NYS &amp; Federal Essential Health Benefit</b>	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered

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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>			
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 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
<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

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Autism Assistive Communication Devices (ACD) State Mandate NYS Essential Health Benefit	Deduct/Specialist Copay	Deduct/Coins	Not Covered
Autologous Blood Banking NYS Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
Durable Medical Equipment (DME) NYS & Federal Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
External Prosthetics 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
Orthotics Foot orthotics included	Not Covered	Not Covered	Not Covered
Medical Supplies NYS & Federal Essential Health Benefit	Deduct/50% Coins	Deduct/50% 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	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months
<b>EMERGENCY SERVICES</b>			
Facility – Emergency Room NYS & Federal Essential Health Benefit	Deduct/\$100 copay	Deduct/\$100 copay	Deduct/\$100 copay
Physician’s Hospital Emergency Room Visit NYS & Federal Essential Health Benefit	Deduct/\$0 copay	Deduct/\$0 copay	Deduct/\$0 copay
Prehospital Emergency Services/Transportation NYS & Federal Essential Health Benefit	Deduct/\$100 copay	Deduct/\$100 copay	Deduct/\$100 copay
Freestanding Urgent Care Center Art 28 Facility NYS & Federal Essential Health Benefit	Deduct/Specialist Copay	Deduct/Coins	Not Covered
Physician’s Freestanding Urgent Care Center (Art 28 Facility) NYS & Federal Essential Health Benefit	Deduct/\$0 copay	Deduct/Coins	Not Covered
Physician Urgent Care Office Visit NYS & Federal Essential Health Benefit	See office visit benefit	See office visit benefit	Not Covered
<b>VISION BENEFITS</b>			
Eye Exams Routine - Adults	Not Covered	Not Covered	Not Covered
Eyewear - Adults	Not Covered	Not Covered	Not Covered
Eye Exams Routine - Pediatric NYS & Federal Essential Health Benefit	Deduct/Specialist Copay 1 per 12 month period	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	Deduct/50%Coins Lenses or Contacts once in any 12 month period Frames once in any 12 month period	Not Covered

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Individual - Gold

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
<b>DENTAL BENEFITS</b>			
Adult Dental	Not Covered	Not Covered	Not Covered
Pediatric Dental - Emergency Care NYS & Federal Essential Health Benefit	Deduct/20% Coins	Deduct/20% Coins	Not Covered
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	Deduct/20% Coins	Deduct/20% Coins	Not Covered
	Deduct/20% Coins	Deduct/20% Coins	Not Covered Platinum Rider: PCP Copay
Preventive - Prophylaxis	Deduct/20% Coins	Deduct/20% Coins	Preventive cost share 1 per six months
Preventive - Topical Fluoride Application	Preventive cost share 1 per six months	Preventive cost share 1 per six months	Preventive cost share 1 per six months
Preventive - Sealants	Preventive cost share 1 per six months	Preventive cost share 1 per six months	Preventive cost share
Preventive - Space Maintainers	Preventive cost share	Preventive cost share	Preventive cost share
Pediatric Dental - Routine NYS & Federal Essential Health Benefit	Deduct/20% Coins	Deduct/20% Coins	Not Covered
	Deduct/20% Coins	Deduct/20% Coins	Not Covered Platinum Rider: PCP Copay
Routine - Exams, Visits & Consults	Routine cost share 1 per six consecutive month period	Routine cost share 1 per six consecutive month period	Routine cost share 1 per six consecutive month period
Routine - Full Mouth X-rays	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
Routine - Bitewing X-rays	Routine cost share 1 per 6 to 12 months	Routine cost share 1 per 6 to 12 months	Routine cost share 1 per 6 to 12 months
Routine - Panoramic X-ray	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
Routine - Other X-rays	Routine cost share	Routine cost share	Routine cost share
Routine - Simple Extractions	Routine cost share	Routine cost share	Routine cost share
Routine - Routine Surgery	Routine cost share	Routine cost share	Routine cost share
Routine - Conscious Sedation	Routine cost share	Routine cost share	Routine cost share
Routine - Restorations - Amalgam, Composite & Other Restorative Materials	Routine cost share	Routine cost share	Routine cost share
Routine - Stainless Steel Crowns	Routine cost share	Routine cost share	Routine cost share
Pediatric Dental - Endodontic NYS & Federal Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
Pediatric Dental - Prosthodontics NYS & Federal Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered

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Individual - Gold

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
Pediatric Dental - Orthodontics NYS & Federal Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>PRESCRIPTION DRUGS</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	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	Copay: \$5 /\$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
Catastrophic	Deduct/Coins		Not Covered
WAITING PERIODS	None		
EXCLUSIONS	Standard Exclusions apply		

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

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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)	
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

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Individual - Silver**

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
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
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

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Individual - Silver**

Benefit Type	Preferred Network	Non-Preferred	Out-of-Network
Substance Use Services NYS & Federal Essential Health Benefit	Deduct/Specialist Copay Unlimited visits. Covers 20 visits per calendar year for family therapy.	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/Specialist Copay 60 visits per condition per lifetime	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/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
Outpatient Hospital & Ambulatory 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 NYS & Federal Essential Health Benefit	Deduct/Coins	Deduct/Coins	Not Covered
Covered Therapies - Rehabilitation 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
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
Additional Surgical Opinion NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
Second Medical Opinion for Cancer NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
Maternity Care: Normal, Complications & Termination. NYS & Federal Essential Health Benefit	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
Prenatal Care HCR Preventive Service NYS & Federal Essential Health Benefit	Covered in full	Covered in full	Not Covered
In-Hospital Physician Visits NYS & Federal Essential Health Benefit	Deduct/Coins	Deduct/Coins	Not Covered
<b>PHYSICIAN OFFICE - OTHER SERVICES</b>			
Diagnostic & Routine Laboratory and Pathology NYS & Federal Essential Health Benefit	Deduct/PCP 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
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	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	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
Substance Use Services NYS & Federal Essential Health Benefit	Deduct/Specialist Copay Excludes family therapy.	Deduct/Coins Excludes family therapy.	Not Covered
Office Visits - Diagnostic NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
Medications Administered in Office NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	Deduct/Coins	Not Covered
Eye Exams - Diagnostic NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
Hearing Evaluations Diagnostic NYS & Federal Essential Health Benefit	Deduct/ Specialist Copay	Deduct/Coins	Not Covered
Chiropractic Care NYS & Federal Essential Health Benefit	Deduct/ Specialist copay	Deduct/Coins	Not Covered
Office & Outpatient Consultations NYS & Federal Essential Health Benefit	Deduct/ PCP/Specialist Copay	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
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 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
<b>ADDITIONAL BENEFITS</b>			
Treatment of Diabetes Insulin & Supplies NYS & Federal Essential Health Benefit	Deduct/ PCP copay	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
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
Autologous Blood Banking NYS Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
Durable Medical Equipment (DME) NYS & Federal Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
External Prosthetics 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
Orthotics Foot orthotics included	Not Covered	Not Covered	Not Covered
Medical Supplies NYS & Federal Essential Health Benefit	Deduct/50% Coins	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	Gym Membership Reimbursement \$200 for member; \$100 for spouse Not subject to Deductible Once every 6 months
<b>EMERGENCY SERVICES</b>			
Facility – Emergency Room 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
Physician’s Hospital Emergency Room Visit NYS & Federal Essential Health Benefit	Deduct/\$0 copay	Deduct/\$0 copay	Deduct/\$0 copay
Prehospital Emergency Services/Transportation 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
Freestanding Urgent Care Center Art 28 Facility NYS & Federal Essential Health Benefit	Deduct/Specialist Copay CSR : Deduct/ \$[10; 25; 50] copay	Deduct/Coins	Not Covered
Physician’s Freestanding Urgent Care Center (Art 28 Facility) NYS & Federal Essential Health Benefit	Deduct/\$0 copay	Deduct/Coins	Not Covered
Physician Urgent Care Office Visit NYS & Federal Essential Health Benefit	See office visit benefit	See office visit benefit	Not Covered
<b>VISION BENEFITS</b>			
Eye Exams Routine - Adults	Not Covered	Not Covered	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
Eyewear - Adults	Not Covered	Not Covered	Not Covered
Eye Exams Routine - Pediatric NYS & Federal Essential Health Benefit	Deduct/Specialist Copay 1 per 12 month period	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	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	Not Covered
Pediatric Dental - Emergency Care NYS & Federal Essential Health Benefit	Deduct/20% Coins	Deduct/20% Coins	Not Covered
Pediatric Dental - Preventive NYS & Federal Essential Health Benefit	Deduct/20% Coins	Deduct/20% Coins	Not Covered
	Deduct/20% Coins	Deduct/20% Coins	Not Covered  Platinum Rider: PCP Copay
Preventive - Prophylaxis	Deduct/20% Coins	Deduct/20% Coins	Preventive cost share 1 per six months
Preventive - Topical Fluoride Application	Preventive cost share 1 per six months	Preventive cost share 1 per six months	Preventive cost share 1 per six months
Preventive - Sealants	Preventive cost share 1 per six months	Preventive cost share 1 per six months	Preventive cost share
Preventive - Space Maintainers	Preventive cost share	Preventive cost share	Preventive cost share
Pediatric Dental - Routine NYS & Federal Essential Health Benefit	Deduct/20% Coins	Deduct/20% Coins	Not Covered
	Deduct/20% Coins	Deduct/20% Coins	Not Covered  Platinum Rider: PCP Copay
Routine - Exams, Visits & Consults	Routine cost share 1 per six consecutive month period	Routine cost share 1 per six consecutive month period	Routine cost share 1 per six consecutive month period
Routine - Full Mouth X-rays	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
Routine - Bitewing X-rays	Routine cost share 1 per 6 to 12 months	Routine cost share 1 per 6 to 12 months	Routine cost share 1 per 6 to 12 months
Routine - Panoramic X-ray	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months	Routine cost share 1 per 36 months
Routine - Other X-rays	Routine cost share	Routine cost share	Routine cost share
Routine - Simple Extractions	Routine cost share	Routine cost share	Routine cost share
Routine - Routine Surgery	Routine cost share	Routine cost share	Routine cost share
Routine - Conscious Sedation	Routine cost share	Routine cost share	Routine cost share
Routine - Restorations - Amalgam, Composite & Other Restorative Materials	Routine cost share	Routine cost share	Routine cost share

**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
Routine - Stainless Steel Crowns	Routine cost share	Routine cost share	Routine cost share
Pediatric Dental - Endodontic NYS & Federal Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
Pediatric Dental - Prosthodontics NYS & Federal Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
Pediatric Dental - Orthodontics NYS & Federal Essential Health Benefit	Deduct/50% Coins	Deduct/50% Coins	Not Covered
<b>PRESCRIPTION DRUGS</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		
Gold	Copay: \$5 /\$35/\$70	Copay: \$5 /\$35/\$70	Not Covered
Silver	\$10/\$35/\$70 No Deductible	\$10/\$35/\$70 No Deductible	Not Covered
Silver 200-250 FPL	\$10/\$35/\$70 No Deductible	\$10/\$35/\$70 No Deductible	Not Covered
Silver 150-200 FPL	\$5/\$25/\$50 No Deductible	\$5/\$25/\$50 No Deductible	Not Covered
Silver 100-150 FPL	\$5/\$25/\$50 No Deductible	\$5/\$25/\$50 No Deductible	Not Covered
Native American 300 FPL	\$0 all tiers	N/A	Not Covered
Catastrophic			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**

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.

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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