Benefit Summary (Effective: 01/01/2014) (Version Updated: 11/13/2013)

Summary of Benefits & Coverage

Summary of Benefits and Coverage (SBC) for this product has been received. Group is responsible for distributing the SBC to all eligible employees in accordance with PPACA requirements.

Group Name:

Please Select Benefit Time Period: Plan Year Calendar Year

H321	Excellus BluePPO Option M-1	
Region: Excellus	Group Size 51-300	
Plan Overview		
Package ID	H321	
Plan Name	Excellus BluePPO Option M-1	
Plan Type	PPO	
Package Status	New-Can quote with 2014 effective date	
Effective Date	01/01/2014	
Activity Status	Active	
Plan features		
Primary Care Physician (PCP)	Not required	
Referrals	Not required	
Out of network benefits	Covered	
Out of area benefits	Coverage provided worldwide through the BlueCard program	
Student/Dependent coverage	Qualified dependents and students are covered to age 26	
Domestic partner	Covered	
Wellness Incentives	Blue365 - Exclusive access to information, discounts & savings	
Plan cost-sharing highlights		
Office visit copay (Primary Care Physician)	No copay, office visit covered at 90% in-network and 80% out-of network, subject to the deductible	
Office visit copay (Specialist)	No copay, office visit covered at 90% in-network and 80% out-of-network, subject to the deductible	
Coinsurance	In-Network: Covered at 90%; Out-of-Network: Covered at 80%	
Deductible	Combined in and Out-of-Network: $1500 Individual / $3000 Family	
Out of pocket maximum	Combined in and Out-of-Network: $3000 Individual / $6000 Family	
Lifetime maximum	None	
Plan Benefits		
Preventive Healthcare Services	**In-Network**	**Out-of-Network**
Well child visits	Covered in full	Covered in full
Adult routine physical exams	Covered in full according to national guidelines	Covered at 80%, subject to the deductible for one routine exam per year
+Adult immunizations	Covered in full	Covered at 80%, subject to the deductible
+Mammography	Covered in full	Covered at 80%, subject to the deductible
+Pap smear	Covered in full	Covered at 80%, subject to the deductible
Routine GYN Exam	Covered in full	Covered at 80%, subject to the deductible
Prostate cancer screening	In-Network: Covered at 90%; Out-of-Network: Cover	Covered at 80%, subject to the deductible
Routine vision	Covered at 90% coins for one routine exam every 2 years. $60 eyewear allowance available every 2 years	Covered at 80%, subject to the deductible for one routine exam every 2 years. $60 eyewear allowance available every 2 years
+Colonoscopy	Preventive and diagnostic covered according to the surgical benefit	Covered at 80%, subject to the deductible
Physician Office Services	**In-Network**	**Out-of-Network**
Diagnostic office visits	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Diagnostic x-rays	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible Precertification applies to MRI, PET and CAT scans

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Diagnostic laboratory and pathology	Covered in full	Covered at 80%, subject to the deductible
Allergy tests	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Allergy injections	Covered in full	Covered at 80%, subject to the deductible
Chemotherapy	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Radiation therapy	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Maternity Services	**In-Network**	**Out-of-Network**
Prenatal care	Covered in full	Covered at 80%, subject to the deductible
Hospital care for mom (including delivery)	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Newborn nursery care	Covered at 90%	Covered at 80%, subject to the deductible
Prescription Drug	**In-Network**	**Out-of-Network**
Short-term and maintenance drugs	$10/$30/$50; $0 copay for generics for members to age 19	Not covered
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Hospital benefits	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible Precertification applies
Physician visits in the hospital	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Inpatient physical rehabilitation	Not Covered	Not covered
Surgery	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Anesthesia	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Emergency Care	**In-Network**	**Out-of-Network**
Emergency room care	Covered at 90%, subject to the deductible	Covered at 90%, subject to the deductible
Freestanding urgent care center	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Ambulance	Covered at 90%, subject to the deductible	Covered at 90%, subject to the deductible
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Diagnostic x-rays	Covered at 90%, subject to the deductible. Precertification applies to MRI, PET and CAT scans	Covered at 80%, subject to the deductible Precertification applies to MRI, PET and CAT scans
Diagnostic laboratory and pathology	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Surgical care	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Chemotherapy	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Radiation Therapy	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Mental Health and Chemical Dependence	**In-Network**	**Out-of-Network**
Inpatient mental health care	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible for unlimited days Precertification applies
Outpatient mental health care	Covered at 90%, subject to the deductible Services can be provided in an outpatient facility or in a provider office	Covered at 80%, subject to the deductible Services can be provided in an outpatient facility or in a provider office
Inpatient chemical dependence	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible Precertification applies
Outpatient chemical dependence	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Other Services	**In-Network**	**Out-of-Network**
Diabetic insulin and supplies	Covered at 90%, subject to the deductible for up to a 30 day supply	Covered at 80%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Covered at 90%, subject to the deductible for up to 120 days per year	Covered at 80%, subject to the deductible for up to 45 days per year
Home care	Covered at 80%, subject to a $50 deductible for unlimited visits per year Precertification applies	Covered at 75%, subject to a $50 deductible for unlimited visits per year Precertification applies
Hospice	Covered at 90%, for unlimited visits per year	Covered at 80%, subject to the deductible unlimited days
Outpatient therapy	Covered at 90%, subject to the deductible for a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 80%, subject to the deductible for up to a combined total of 45 visits per year for physical, speech, respiratory and occupational therapy
Durable medical equipment	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
External prosthetics	Covered at 90%, subject to the deductible	Covered at 80%, subject to the deductible
Chiropractic	Covered at 90%, subject to the deductible	Covered at 80%, subject to deductible
Acupuncture	Not covered	Not covered
Dental	Covered at 90%, subject to the deductible for accidental injury to sound, natural teeth and for care	Covered at 80%, subject to deductible for accidental injury to sound, natural teeth and for care due to

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	due to congenital disease or anomaly	congenital disease or anomaly
Hearing	Covered at 90%, subject to the deductible, for one routine hearing exam per year Two hearing aids allowed every three years for members to age 19	Routine exams not covered Two hearing aids allowed every three years for members to age 19

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. +Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.