

**Excellus BC/BS
Individual Rates**

**Rome Area Chamber of Commerce
January 1, - December 31, 2019**

Plan ID	78124NY0880009-00	78124NY0880003-00	78124NY0890003-00	78124NY0890015-00	78124NY0890019-00	78124NY0890009-00	78124NY0890025-00	78124NY0900009-00
Enrollment Code	IOOS	INNU	IOOA	IOOW	IMMW	IOOG	INNA	IPPA
Plan Type	Copay	Copay	Hybrid	Hybrid	Hybrid	Hybrid	Hybrid	HDHP
Plan Name	Platinum Select	Platinum Standard	Gold Standard	Gold Select	Gold Standard Plus 3	Silver Standard	Silver Standard Plus 3	Silver Select
Single	\$946.97	\$968.36	\$824.68	\$799.08	\$816.79	\$709.47	\$686.06	\$638.84
Subscriber/Spouse	\$1,893.94	\$1,936.71	\$1,649.35	\$1,598.17	\$1,633.59	\$1,418.94	\$1,372.12	\$1,277.68
Subscriber/Child(ren)	\$1,609.85	\$1,646.20	\$1,401.95	\$1,358.44	\$1,388.55	\$1,206.10	\$1,166.29	\$1,086.03
Family	\$2,698.87	\$2,759.82	\$2,350.32	\$2,277.39	\$2,327.86	\$2,021.99	\$1,955.27	\$1,820.69
Primary Care Office Visit	\$15 copay per visit	\$15 copay per visit	\$25 copay per visit, subject to deductible	\$25 copay per visit, subject to deductible	First 3 visits not subject to deductible - \$25 copay per visit, subject to deductible	\$30 copay per visit, subject to deductible	First 3 visits not subject to deductible - \$35 copay per visit, subject to deductible	Covered at 80%, subject to the deductible
Specialist Office Visit	\$25 copay per visit	\$35 copay per visit	\$40 copay per visit, subject to deductible	\$40 copay per visit, subject to deductible	\$40 copay per visit, subject to deductible	\$50 copay per visit, subject to deductible	\$55 copay per visit, subject to deductible	Covered at 80%, subject to the deductible
Deductible	None	None	\$600 Individual / \$1,200 Family	\$750 Individual / \$1,500 Family	\$650 Individual / \$1,300 Family	\$1,700 Individual / \$3,400 Family	\$2,350 Individual / \$4,700 Family	\$2,250 Individual / \$4,500 Family
Coinsurance	None	None	None	None	None	None	None	Covered at 80%
Hospital benefits	Subject to \$750 copay per admission for unlimited days	Subject to \$500 copay per admission for unlimited days	Subject to \$1000 copay per admission for unlimited days, subject to the deductible	Subject to \$750 copay per admission for unlimited days, subject to the deductible	Subject to \$1000 copay per admission for unlimited days, subject to the deductible	Subject to \$1500 copay per admission for unlimited days, subject to the deductible	Subject to \$1500 copay per admission for unlimited days, subject to the deductible	Covered at 80% per admission for unlimited days, subject to the deductible
Emergency room care Urgent Care	\$150 copay per visit \$25 copay per visit	\$100 copay per visit \$55 copay per visit	\$150 copay per visit, subject to deductible. \$60 copay per visit subject to deductible.	\$250 copay per visit, subject to deductible. \$40 copay per visit subject to deductible.	\$150 copay per visit, subject to deductible. \$60 copay per visit subject to deductible.	\$250 copay per visit, subject to deductible. \$70 copay per visit subject to deductible.	\$250 copay per visit, subject to deductible. \$70 copay per visit subject to deductible.	Covered at 80%, subject to the deductible. Same as above.
Short-term and maintenance drugs	\$10/\$35/\$70	\$10/\$30/\$60	\$10/\$35/\$70	\$10/\$35/\$70	\$10/\$40/\$80	\$10/\$35/\$70	\$10/\$40/\$80	\$10/\$45/\$90, subject to the plan deductible
Wellness Incentives	ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues	ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues	ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues	ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues	ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues	ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues	ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues	ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues
Out of pocket maximum	\$6,350 Individual / \$12,700 Family	\$2,000 Individual / \$4,000 Family	\$4,000 Individual / \$8,000 Family	\$6,350 Individual / \$12,700 Family	\$5,000 Individual / \$10,000 Family	\$7,500 Individual / \$15,000 Family	\$7,750 Individual / \$15,500 Family	\$6,350 Individual / \$12,700 Family
Out of network benefits	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Preventive Health Care Services	Covered in full	Covered in full	Covered in full	Preventive Health Care is not subject to the deductible. Covered in full	Covered in full	Covered in full	Covered in full	Preventive Health Care is not subject to the deductible. Covered in full

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Plan ID	78124NY0900017-00	78124NY0900013-00	78124NY0900017-00
Enrollment Code	IPPY	IPPE	IPPY
Plan Type	HDHP	HDHP	HDHP
Plan Name	Bronze Standard	Bronze Select	Bronze Secure Plus 3
Single	\$520.33	\$486.65	\$433.03
Subscriber/Spouse	\$1,040.66	\$973.30	\$866.06
Subscriber/Child(ren)	\$884.56	\$827.31	\$736.15
Family	\$1,482.93	\$1,386.95	\$1,234.13
Primary Care Office Visit	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	First 3 visits covered in full. Next visits covered @ 100%, subject to deductible
Specialist Office Visit	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 100%, subject to the deductible
Deductible	\$4,000 Individual / \$8,000 Family	\$5,000 Individual / \$10,000 Family	\$7,900 Individual / \$15,800 Family
Coinsurance	Covered at 50%	Covered at 50%	Covered at 100%
Hospital benefits	Covered at 50% per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible
Emergency room care Urgent Care	Covered at 50%, subject to the deductible. Same as above.	Covered at 50%, subject to the deductible. Same as above.	Covered at 100% subject to the deductible
Short-term and maintenance drugs	\$10/\$35/\$70, subject to the plan deductible	\$10/40%/50%, subject to deductible	\$0, subject to the plan deductible
Wellness Incentives	ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues	ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues	ExerciseRewards™ receive up to \$600 a year toward qualified fitness facility dues
Out of pocket maximum	\$7,600 Individual / \$15,200 Family	\$6,550 Individual / \$13,100 Family	\$7,900 Individual / \$15,800 Family
Out of network benefits	Not Covered	Not Covered	Not Covered
Preventive Health Care Services	Preventive Health Care is not subject to the deductible. Covered in full	Preventive Health Care is not subject to the deductible. Covered in full	Preventive Health Care is not subject to the deductible. Covered in full