

Quote Effective: 10/01/2023 - 12/31/2023

Version Updated: 09/11/2022

Print Package: HIOS ID (Enrollment Code)	78124NY1000202-00 (TVVE)			
Plan Name:	SimplyBlue Plus Bronze 5			
Rating Region:	Syracuse			
Rate				
For the Benefits described in the Agreement, the Plan will cha	rge and Group will pay the following p	remium rates:		
Single	\$586.28			
Subscriber & Spouse	\$1,172.56			
Subscriber & Child(ren)	\$996.68			
Family	\$1,670.90			
Dependent Coverage To Age 26, Pediatric Dental Coverage No, D	Domestic Partner Coverage Yes , Family P	lanning Coverage Yes		
Rates quoted herein are subject to change due to our implementate	ion of the provisions of the Federal Patien	it Protection and Affordable Care Act.		
The Sales Representative providing this quote is a New York State licensed insurance producer employed by Excellus Health Plan. The individual represents Excellus Health Plan in this transaction and will be compensated by Excellus Health Plan in part based on this sale. The amount of compensation is based on a number of factors, including the contract selected and the volume of sales. You may request information about the expected compensation from your Sales Representative.				
*The NYS Department of Financial Services has approved our rate filing for quarterly community rates. All Rates will be considered to be on a 12 month period from the effective date of coverage unless otherwise instructed by Excellus Health Plan. The above rates are effective for the Initial Term of the Agreement. Rates for any Renewal Term will be provided to Group in a rate renewal notice.				
Please complete this section if you have selected a plan that (A). Have you obtained dental coverage, not offered by Excellus BO Yes No B.) If you answered 'yes', please provide the name of the company If you change this dental coverage at any time, you must notify Ex If you answered 'no' please be aware the ACA requires essential provided the second of the company of the second of the company is not the second of the	CBS, that provides essential pediatric dent r issuing the essential pediatric dental cov cellus BCBS to confirm continued coverage	tal benefits through a NY State of Heal	th certified dental plan?	
	<u> </u>			
Signature:	Title:		Date:]
Group Name:	Total Employees:		Total Eligible:	
Coverage Effective Date:				
Broker				

	SimplyBlue Plus Bronze 5				
Plan Overview					
Plan ID	78124NY1000202-00 (TVVE)				
Plan Name	SimplyBlue Plus Bronze 5				
Aggregation Design	Family Aggregation				
Plan Highlights	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes Active&Fit ExerciseRewards.				
Plan Type	Deductible HSA				
HSA Eligible	Yes				
Quote Effective	10/01/2023 - 12/31/2023				
Plan features					
Primary Care Physician (PCP)	Not Required				
Referrals	Not Required				
Out of network benefits	Covered at 100%, subject to the deductible				
Out of area benefits	Coverage provided worldwide through our BlueCard® Network				
Student/Dependent coverage	Qualified dependents are covered to age 26				
Domestic partner	Covered				
Wellness Incentives	Active&Fit ExerciseRewards: New in 2023 - Fitness center visits are worth 2 points! Earn up to \$600 in rewards a year by visiting a qualified fitness facility or by tracking your steps using a wearable device. Save on Gym memberships with Active&Fit Enterprise.				
Calm Stress Management Program	New in 2023, a premium subscription to the Calm App is now an embedded benefit to help members experience better sleep, lower stress, and reduce anxiety.				
Plan cost-sharing highligh	ts				
Plan cost-sharing highlights	In-Network	Out-of-Network			
Primary Care Office Visit	\$40 copay per visit, subject to deductible	Covered at 100%, subject to the deductible			
Specialist Office Visit	\$60 copay per visit, subject to deductible	Covered at 100%, subject to the deductible			
Coinsurance	Covered at 100%	Covered at 100%			
Deductible	In-Network: \$6,000 Individual / \$12,000 Family	Out-of-Network: \$10,000 Individual / \$20,000 Family			
Out of pocket maximum	\$7,500 Individual / \$15,000 Family	\$10,000 Individual / \$20,000 Family			
Lifetime maximum	None None				
Plan Benefits					
Preventive Healthcare Services	In-Network	Out-of-Network			
Well child visits	Covered In Full	Covered at 100%, subject to the deductible			
Adult routine physical exams	Covered In Full	Covered at 100%, subject to the deductible			
+Adult immunizations	Covered In Full	Covered at 100%, subject to the deductible			
+Mammography	Covered In Full	Covered at 100%, subject to the deductible			
+Pap smear	Covered In Full	Covered at 100%, subject to the deductible			
Routine GYN Exam	Covered In Full	Covered at 100%, subject to the deductible			

#Prostate cancer sozienting with Full sozienting services and Full Covered in Full Covered in 100%, subject to the deductable Covered in Full Covered in Full Covered in Full Covered in 100%, subject to the deductable Covered in Full Subject to deductable Covered in Full Subject to the deductab		SimplyBlue Plus Bronze 5		
#Family Planning Services Covered at 100%, subject to the deductible		Covered In Full	Covered at 100%, subject to the deductible	
Female Services Covered in Full Covered at 100%, subject to the deductible				
Physician Office Services Diagnostic Visits Telemedicine with MDLive Diagnostic Arrays Sido Copay per visit, subject to deductible Covered at 100%, subject to the deductible Covered at 100%, su		Preventive screenings covered in full	Covered at 100%, subject to the deductible	
Services Covered at 100%, subject to the deductible Covered	+Family Planning Services	Covered In Full	Covered at 100%, subject to the deductible	
In-Person or Virtual Telemedicine with MDLve Diagnostic x-rays \$60 copsy per visit, subject to deductible Covered at 100%, subject to the deductible Allergy tests 400 PCP copay; \$80 Specialist copay per visit, subject to deductible Covered at 100%, subject to the deductible Allergy injections \$40 PCP copay; \$80 Specialist copay per visit, subject to deductible Covered at 100%, subject to the deductible C	-	In-Network	Out-of-Network	
Diagnostic x-rays \$60 copay per visit, subject to deductible Advanced Imaging \$100 copay per visit, subject to the deductible Covered at 100%, subject to the deductible Advanced Imaging \$40 copay per visit, subject to deductible Covered at 100%, subject to the deductible Covered at 100% per admission, subject to the deductible Covered at 100% per admission, subject to the deductible Covered at 100% per admission, subject to the deductible Covered at 100% per admission, subject to the deductible Covered at 100% per admission, subject to the deductible Covered at 100% per admission, subject to the deductible Covered at 100% per admission, subject to the deductible Covered at 100%, subject to the deductib		\$40 PCP copay; \$60 Specialist copay per visit, subject to deductible.	Covered at 100%, subject to the deductible	
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Services Disposatic laboratory and pathology Allergy tests All CPC popay; \$60 Specialist copay per visit, subject to deductible Covered at 100%, subject to the deductible Covered at 100% per admission, subject to the deductible Covered at 100% per admission, subject to the deductible Covered at 100%, subject to the deductible Covered at 100%, subject to the deductible Covered at 100% per admission for unlimited days, subject to the deductible Covered at 100%, subject to the deductible Covered	Diagnostic x-rays	\$60 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	
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Chemotherapy \$40 PCP copay per visit, subject to deductible Radiation therapy \$60 PCP copay per visit, subject to deductible Covered at 100%, subject to the deductible Covered at 100%, subject to the deductible Maternity Services In-Network Covered in full (Cost share may apply to ultrasounds, lab work and sick visits) Covered at 100%, subject to the deductible Covered at 100%, subject to the deductible Covered at 100%, subject to the deductible Covered at 100% per admission, subject to the deductible Covered at 100% per admission, subject to the deductible Prescription Drug In-Network Prescription Drug S10/845/\$90, subject to the plan deductible. Preventive drugs are not subject to the deductible; Diabetic drugs, insulin, and \$40 copay, subject to deductible per 30 day supply supplies In-Network In-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Covered at 100%, subject to the deductible Emergency Care In-Network Out-of-Network Out-of-Network Covered at 100%, subject to the deductible Covered at 100%, subject to the deductible Covered at 100%, subject to the deductible Covered at 100%, subject to the deduc	Allergy tests	\$40 PCP copay; \$60 Specialist copay per visit, subject to deductible	Covered at 100%, subject to the deductible	
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Prenatal care Covered in full (Cost share may apply to ultrasounds, lab work and sick visits) Covered at 100%, subject to the deductible Hospital care for mom (including delivery) Newborn nursery care Covered in Full, subject to deductible Prescription Drug In-Network Prescription Drug \$10,45/\$90, subject to the plan deductible. Preventive drugs are not subject to the deductible; they are subject to the applicable copar or coinsurance. Diabetic drugs, insulin, and supplies In-Network Hospital benefits Subject to \$1,000 copay per admission for unlimited days, subject to the deductible Covered at 100%, subject to the deductible Covered at 100%, subject to the deductible Not Covered Covered at 100%, subject to the deductible Not Covered Covered at 100%, subject to the deductible Covered at 100%, subject to the deductible Covered at 100%, subject to the deductible Freestanding urgent care Freestanding urgent care S60 copay per visit, subject to deductible Covered at 100%, subject to the deductible	Radiation therapy	\$60 PCP copay per visit, subject to deductible	Covered at 100%, subject to the deductible	
Hospital care for mom (including delivery) Newborn nursery care Covered In Full, subject to deductible Covered at 100% per admission, subject to the deductible Covered at 100% per admission, subject to the deductible Covered at 100% per admission, subject to the deductible Prescription Drug Prescription Drug S10%45/\$90, subject to the plan deductible. Preventive drugs are not subject to the deductible; they are subject to the applicable copay or coinsurance. Diabetic drugs, insulin, and supplies \$40 copay, subject to deductible per 30 day supply Covered at 100%, subject to the deductible In-Network In-Network Dut-of-Network Out-of-Network Out-of-Network Covered at 100%, subject to the deductible Physician visits in the hospital benefits Subject to \$1,000 copay per admission for unlimited days, subject to the deductible Covered at 100%, subject to the deductible Emergency Care In-Network Emergency Care \$60 copay per visit, subject to deductible Covered at 100%, subject to the deductible Covered	Maternity Services	In-Network	Out-of-Network	
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Emergency room care \$500 copay per visit, subject to deductible \$500 copay per visit, subject to deductible \$60 copay per visit, subject to deductible Covered at 100%, subject to the deductible	Anesthesia	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible	
Freestanding urgent care \$60 copay per visit, subject to deductible Covered at 100%, subject to the deductible	Emergency Care	In-Network	Out-of-Network	
	Emergency room care	\$500 copay per visit, subject to deductible	\$500 copay per visit, subject to deductible	
		\$60 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	
Ambulance \$500 copay per visit, subject to deductible \$500 copay per visit, subject to deductible	Ambulance	\$500 copay per visit, subject to deductible	\$500 copay per visit, subject to deductible	

Dutpatient Hospital Benefits	
Diagnostic x-rays \$60 copay per visit, subject to the deductible Advanced Imaging Services Diagnostic laboratory and pathology Surgical Care Facility Fee \$500 copay per visit, subject to the deductible Chemotherapy Radiation Therapy \$60 copay per visit, subject to the deductible Radiation Therapy S60 copay per visit, subject to the deductible Radiation Therapy Rental Health and Substance Use Impatient mental health care Coutpatient mental health care Subject to \$1,000 copay per admission for unlimited days, subject to the deductible Inpatient substance use Coutpatient substance use Coutpatient substance use Subject to \$1,000 copay per admission for unlimited days, subject to the deductible Coutpatient substance use Coutpatient substance use Skilled nursing facility Subject to \$1,000 copay per admission for unlimited days, subject to the deductible Coutpatient substance use Skilled nursing facility Subject to \$1,000 copay per admission for up to 200 days per year, subject to the deductible Home care \$40 copay per visit for 40 visits per year, subject to the deductible Hospice Subject to \$1,000 copay per admission for up to 200 days per year, subject to the deductible Hospice Subject to \$1,000 copay per admission for up to 200 days per year, subject to the deductible Hospice Subject to \$1,000 copay per admission for up to 210 days per year, subject to the deductible Coutpatient therapy \$40 copay per visit, subject to deductible for physical, speech and occupational therapy for up to visits per contract year Durable medical equipment External prosthetics Covered at 50%, subject to the deductible Chiropractic \$40 copay per visit, subject to deductible Acupuncture \$60 copay per visit, subject to deductible Covered at 50%, subject to the deductible Nearing Aids Covered at 50%, subject to the deductible Farmal Prosthetics Covered at 50%, subject to fell per year, subject to the deductible S60 copay per visit, subject to deductible Covered at 50% operated at 50% operate	Out-of-Network
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Diagnostic laboratory and pathology Surgical Care Facility Fee Chemotherapy \$40 copay per visit; subject to the deductible Chemotherapy \$40 copay per visit; subject to deductible Radiation Therapy \$40 copay per visit; subject to the deductible Radiation Therapy \$60 copay per visit, subject to the deductible Mental Health and Substance Use Impatient mental health care Outpatient mental health care Subject to \$1,000 copay per admission for unlimited days, subject to the deductible care Inpatient substance use Outpatient substance use Subject to \$1,000 copay per admission for unlimited days, subject to the deductible Other Services In-Network Skilled nursing facility Subject to \$1,000 copay per admission for unlimited days, subject to the deductible Other Services In-Network Skilled nursing facility Subject to \$1,000 copay per admission for up to 200 days per year, subject to the deductible Hospice Subject to \$1,000 copay per admission for up to 200 days per year, subject to the deductible Outpatient therapy Subject to \$1,000 copay per admission for up to 210 days per year, subject to the deductible Outpatient therapy Subject to \$1,000 copay per admission for up to 210 days per year, subject to the deductible Outpatient therapy Subject to \$1,000 copay per admission for up to 210 days per year, subject to the deductible Outpatient therapy Subject to \$40 copay per visit, subject to deductible for physical, speech and occupational therapy for up to visits per contract year Durable medical equipment External prosthetics Covered at 50%, subject to the deductible Acupuncture \$60 copay per visit, subject to deductible Acupuncture \$60 copay per visit, subject to deductible Acupuncture \$60 copay per visit, subject to deductible Therefore the deductible Acupuncture \$60 copay per visit, subject to deductible Acupuncture \$60 copay per visit, subject to deductible Therefore the deductible One routine exam covered in full per year, subject to the deductible Dediatric Routine Vision Covered at 50%,	Covered at 100%, subject to the deductible
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Skilled nursing facility Subject to \$1,000 copay per admission for up to 200 days per year, subject to the deductible Hospice Subject to \$1,000 copay per admission for up to 210 days per year, subject to the deductible Outpatient therapy \$40 per visit, subject to deductible for physical, speech and occupational therapy for up to visits per contract year Durable medical equipment External prosthetics Covered at 50%, subject to the deductible Chiropractic \$40 copay per visit, subject to deductible Acupuncture \$60 copay per visit, subject to deductible Hearing Aids Covered at 50%, subject to the deductible Covered at 50%, subject to the deductible Hearing Aids Covered at 50%, subject to the deductible for a single purchase once every 3 years Vision Benefits In-Network Adult Routine Vision Exam One routine exam covered in full per year, subject to the deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Pediatric Routine Vision Exam Pediatric Eyewear Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 100%, subject to the deductible
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visits per contract year Durable medical equipment External prosthetics Covered at 50%, subject to the deductible Chiropractic \$40 copay per visit, subject to deductible Acupuncture \$60 copay per visit, subject to deductible Hearing Aids Covered at 50%, subject to the deductible for a single purchase once every 3 years Vision Benefits In-Network Adult Routine Vision Exam One routine exam covered in full per year, subject to the deductible Adult Diagnostic Vision \$60 copay per visit, subject to deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Pediatric Routine Vision One routine exam covered in full per year, subject to the deductible Covered at 50%, subject to the deductible for one purchase per plan year	tible Covered at 100% for up to 210 visits per year, subject to the deductible
equipment External prosthetics Covered at 50%, subject to the deductible Chiropractic \$40 copay per visit, subject to deductible Acupuncture \$60 copay per visit, subject to deductible Hearing Aids Covered at 50%, subject to the deductible for a single purchase once every 3 years Vision Benefits In-Network Adult Routine Vision Exam One routine exam covered in full per year, subject to the deductible Adult Diagnostic Vision \$60 copay per visit, subject to deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Pediatric Routine Vision Exam One routine exam covered in full per year, subject to the deductible Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 100%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year
Chiropractic \$40 copay per visit, subject to deductible Acupuncture \$60 copay per visit, subject to deductible Hearing Aids Covered at 50%, subject to the deductible for a single purchase once every 3 years Vision Benefits In-Network Adult Routine Vision Exam One routine exam covered in full per year, subject to the deductible Adult Diagnostic Vision \$60 copay per visit, subject to deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Pediatric Routine Vision Exam One routine exam covered in full per year, subject to the deductible Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 50%, subject to the deductible
Acupuncture \$60 copay per visit, subject to deductible Hearing Aids Covered at 50%, subject to the deductible for a single purchase once every 3 years Vision Benefits In-Network Adult Routine Vision Exam One routine exam covered in full per year, subject to the deductible Adult Diagnostic Vision \$60 copay per visit, subject to deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Pediatric Routine Vision Exam One routine exam covered in full per year, subject to the deductible Exam Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 50%, subject to the deductible
Hearing Aids Covered at 50%, subject to the deductible for a single purchase once every 3 years Vision Benefits In-Network Adult Routine Vision Exam One routine exam covered in full per year, subject to the deductible Adult Diagnostic Vision \$60 copay per visit, subject to deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Pediatric Routine Vision Exam One routine exam covered in full per year, subject to the deductible Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 100%, subject to the deductible
Vision Benefits In-Network Adult Routine Vision Exam One routine exam covered in full per year, subject to the deductible Adult Diagnostic Vision \$60 copay per visit, subject to deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Pediatric Routine Vision Exam Pediatric Eyewear Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 100%, subject to the deductible
Adult Routine Vision Exam One routine exam covered in full per year, subject to the deductible Adult Diagnostic Vision \$60 copay per visit, subject to deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Pediatric Routine Vision Exam One routine exam covered in full per year, subject to the deductible Pediatric Eyewear Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 50%, subject to the deductible for a single purchase once every 3 years
Adult Diagnostic Vision \$60 copay per visit, subject to deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Pediatric Routine Vision Exam Pediatric Eyewear Covered at 50%, subject to the deductible for one purchase per plan year	Out-of-Network
Adult Eyewear Eyewear Reimbursement of \$100 per year Pediatric Routine Vision Exam Pediatric Eyewear Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 100% for one routine exam every year, subject to the deductible
Pediatric Routine Vision Exam One routine exam covered in full per year, subject to the deductible Pediatric Eyewear Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 100%, subject to the deductible
Exam Pediatric Eyewear Covered at 50%, subject to the deductible for one purchase per plan year	Eyewear Reimbursement of \$100 per year
	Covered at 100% for one routine exam every year, subject to the deductible
Dental Benefits In-Network	Covered at 50%, subject to the deductible for one purchase per plan year
	Out-of-Network
Adult Dental Care Not Covered	Not Covered
Pediatric Dental: Preventative & Routine Not Covered	Not Covered

	SimplyBlue Plus Bronze 5		
Pediatric Major Dental Care & Medical Ortho	Not Covered	Not Covered	
		Covered at 100% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	

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.

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