Excellus LIVE FEARLESS

Quote Effective: 07/01/2022 - 09/30/2022

Version Updated: 10/28/2021

Print Package: HIOS ID (Enrollment Code)	**78124NY0980025-00 (SXN9)**	**78124NY0990249-00 (SYS3)**	**78124NY1000057-00 (SXX5)**	**78124NY1000169-00 (SYA7)**
Plan Name:	**SimplyBlue Plus Platinum 2**	**SimplyBlue Plus Gold 17**	**SimplyBlue Plus Silver 2**	**SimplyBlue Plus Bronze 4**
Rating Region:	**Syracuse**	**Syracuse**	**Syracuse**	**Syracuse**
Rate				
For the Benefits described in the Agreement, the Plan will charge and Group will pay the following premium rates:				
Single	$1,002.79	$818.73	$679.07	$534.90
Subscriber & Spouse	$2,005.58	$1,637.46	$1,358.14	$1,069.80
Subscriber & Child(ren)	$1,704.74	$1,391.84	$1,154.42	$909.33
Family	$2,857.95	$2,333.38	$1,935.35	$1,524.47
Dependent Coverage To Age **26**, Pediatric Dental Coverage **Yes**, Domestic Partner Coverage **Yes**, Family Planning Coverage **Yes**				
Rates quoted herein are subject to change due to our implementation of the provisions of the Federal Patient 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 does not include pediatric dental coverage. A). Have you obtained dental coverage, not offered by Excellus BCBS, that provides essential pediatric dental benefits through a NY State of Health certified dental plan? **Yes** ☐ **No** ☐ B.) If you answered 'yes', please provide the name of the company issuing the essential pediatric dental coverage. _____ If you change this dental coverage at any time, you must notify Excellus BCBS to confirm continued coverage of essential pediatric benefits. If you answered 'no' please be aware the ACA requires essential pediatric dental coverage.				

Signature: _____ **Title:** _____ **Date:** _____

Group Name: _____ **Total Employees:** _____ **Total Eligible:** _____

Coverage Effective Date: _____

Broker: _____

	SimplyBlue Plus Platinum 2	SimplyBlue Plus Gold 17	SimplyBlue Plus Silver 2	SimplyBlue Plus Bronze 4
Plan Overview				
Plan ID	78124NY0980025-00 (SXN9)	78124NY0990249-00 (SYS3)	78124NY1000057-00 (SXX5)	78124NY1000169-00 (SYA7)
Plan Name	SimplyBlue Plus Platinum 2	SimplyBlue Plus Gold 17	SimplyBlue Plus Silver 2	SimplyBlue Plus Bronze 4
Aggregation Design	Individual Aggregation	Individual Aggregation	Family Aggregation	Family Aggregation
Plan Highlights	Predictable out-of-pocket costs without a deductible, includes Active&Fit ExerciseRewards.	A deductible is applied to select covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full, includes Active&Fit ExerciseRewards.	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes Active&Fit ExerciseRewards.	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	Copay	Hybrid	Deductible HSA	Deductible HSA
HSA Eligible	No	No	Yes	Yes
Quote Effective	07/01/2022 - 09/30/2022	07/01/2022 - 09/30/2022	07/01/2022 - 09/30/2022	07/01/2022 - 09/30/2022
Plan features				
Primary Care Physician (PCP)	Not Required	Not Required	Not Required	Not Required
Referrals	Not Required	Not Required	Not Required	Not Required
Out of network benefits	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible
Out of area benefits	Coverage provided worldwide through our BlueCard Network	Coverage provided worldwide through our BlueCard Network	Coverage provided worldwide through our BlueCard Network	Coverage provided worldwide through our BlueCard Network
Student/Dependent coverage	Qualified dependents are covered to age 26	Qualified dependents are covered to age 26	Qualified dependents are covered to age 26	Qualified dependents are covered to age 26
Domestic partner	Covered	Covered	Covered	Covered
Wellness Incentives	Active&Fit ExerciseRewards receive 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 Direct.	Active&Fit ExerciseRewards receive 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 Direct.	Active&Fit ExerciseRewards receive 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 Direct.	Active&Fit ExerciseRewards receive 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 Direct.

Plan cost-sharing highlights								
Plan cost-sharing highlights	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Primary Care Office Visit	$15 copay per visit	Covered at 80%, subject to the deductible	$30 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Specialist Office Visit	$25 copay per visit	Covered at 80%, subject to the deductible	$50 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Coinsurance	None	Covered at 80%	Covered at 80%	Covered at 60%	Covered at 80%	Covered at 60%	Covered at 100%	Covered at 100%
Deductible	None	Out-of-Network: $5,000 Individual / $10,000 Family	In-Network: $1,000 Individual / $2,000 Family	Out-of-Network: $5,000 Individual / $10,000 Family	In-Network: $2,600 Individual / $5,200 Family	Out-of-Network: $5,000 Individual / $10,000 Family	In-Network: $7,000 Individual / $14,000 Family	Out-of-Network: $10,000 Individual / $20,000 Family
Out of pocket maximum	$5,000 Individual / $10,000 Family	$10,000 Individual / $20,000 Family	$8,150 Individual / $16,300 Family	$10,000 Individual / $20,000 Family	$7,000 Individual / $14,000 Family	$10,000 Individual / $20,000 Family	$7,000 Individual / $14,000 Family	$10,000 Individual / $20,000 Family
Lifetime maximum	None	None	None	None	None	None	None	None
Plan Benefits								

	SimplyBlue Plus Platinum 2		SimplyBlue Plus Gold 17		SimplyBlue Plus Silver 2		SimplyBlue Plus Bronze 4	
Preventive Healthcare Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Well child visits	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
Adult routine physical exams	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
+Adult immunizations	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
+Mammography	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
+Pap smear	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
Routine GYN Exam	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
+Prostate cancer screening	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
+Colonoscopy	Preventive screenings covered in full	Covered at 80%, subject to the deductible	Preventive screenings covered in full	Covered at 60%, subject to the deductible	Preventive screenings covered in full	Covered at 60%, subject to the deductible	Preventive screenings covered in full	Covered at 100%, subject to the deductible
+Family Planning Services	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
Physician Office Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic office visits	$15 PCP copay; $25 Specialist copay per visit	Covered at 80%, subject to the deductible	$30 PCP copay; $50 Specialist copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Telemedicine and Telehealth Services	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full, subject to deductible	Covered at 60%, subject to the deductible	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible
Diagnostic x-rays	$25 copay per visit	Covered at 80%, subject to the deductible	$50 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	Covered at 80%, subject to the deductible	$100 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Diagnostic laboratory and pathology	$15 copay per visit	Covered at 80%, subject to the deductible	$30 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Allergy tests	$15 PCP copay; $25	Covered at 80%,	$30 PCP copay; $50	Covered at 60%,	Covered at 80%,	Covered at 60%,	Covered at 100%,	Covered at 100%,

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	Specialist copay per visit	subject to the deductible	Specialist copay per visit	subject to the deductible	subject to the deductible	subject to the deductible	subject to the deductible	subject to the deductible
Allergy injections	$15 PCP copay; $25 Specialist copay per visit	Covered at 80%, subject to the deductible	$30 PCP copay; $50 Specialist copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Chemotherapy	$15 copay per visit	Covered at 80%, subject to the deductible	$30 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Radiation therapy	$25 copay per visit	Covered at 80%, subject to the deductible	$50 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Maternity Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prenatal care	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered at 80%, subject to the deductible per admission	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered at 60%, subject to the deductible	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered at 60%, subject to the deductible	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)	Subject to $500 copay per admission	Covered at 80%, per admission, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Newborn nursery care	Covered In Full	Covered at 80%, per admission, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Prescription Drug	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Coverage	$5/$35/$70	Not Covered	$10/$45/$90	Not Covered	$5/$45/$90, subject to the plan deductible. Preventive drugs are not subject to the deductible; they are subject to the applicable copay or coinsurance.	Not Covered	Covered at 100%, subject to the plan deductible. Preventive drugs are not subject to the deductible; they are subject to the applicable copay or coinsurance.	Not Covered
Diabetic drugs, insulin, and supplies	$15 copay per 30 day supply	Covered at 80%, subject to the deductible	$30 copay per 30 day supply	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital benefits	Subject to $500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Covered at 80% per admission for unlimited days, subject to the deductible	Covered at 60% per admission for unlimited days, subject to the deductible	Covered at 80% per admission for unlimited days, subject to the deductible	Covered at 60% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible
Physician visits in the hospital	Covered In Full	Covered at 80%, subject to the deductible per admission	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Inpatient physical rehabilitation	Subject to $500 copay per admission for up to 60 days per	Covered at 80%, per admission for up to 60 days per contract	Covered at 80% per 60 day stay per admission per	Covered at 60% per 60 day stay per admission per	Covered at 80% per 60 day stay per admission per	Covered at 60% per 60 day stay per admission per	Covered at 100% per 60 day stay per admission per	Covered at 100% per 60 day stay per admission per

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	contract year	year, subject to the deductible	contract year, subject to the deductible	contract year, subject to the deductible	contract year, subject to the deductible	contract year, subject to the deductible	contract year, subject to the deductible	contract year, subject to the deductible
Surgery	Covered In Full	Covered at 80%, subject to the deductible per admission	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Anesthesia	Covered In Full	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Emergency Care	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency room care	$150 copay per visit	$150 copay per visit	$250 copay per visit	$250 copay per visit	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Freestanding urgent care center	$25 copay per visit	Covered at 80%, subject to the deductible	$50 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Ambulance	$150 copay	$150 copay	$250 copay per visit	$250 copay per visit	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic x-rays	$25 copay per visit	Covered at 80%, subject to the deductible	$50 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	Covered at 80%, subject to the deductible	$100 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Diagnostic laboratory and pathology	$15 copay per visit	Covered at 80%, subject to the deductible	$30 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Surgical Care Facility Fee	$150 copay per visit	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Chemotherapy	$15 copay per visit	Covered at 80%, subject to the deductible	$30 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Radiation Therapy	$25 copay per visit	Covered at 80%, subject to the deductible	$50 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Mental Health and Substance Use	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient mental health care	Subject to $500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Covered at 80% per admission for unlimited days, subject to the deductible	Covered at 60% per admission for unlimited days, subject to the deductible	Covered at 80% per admission for unlimited days, subject to the deductible	Covered at 60% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible
Outpatient mental health	3 visits covered in full.	Covered at 80%,	3 visits covered in full.	Covered at 60%,	Covered at 80%,	Covered at 60%,	Covered at 100%,	Covered at 100%,

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care	Next visits covered at $15 copay per visit	subject to the deductible	Next visits covered at $30 copay per visit	subject to the deductible	subject to the deductible	subject to the deductible	subject to the deductible	subject to the deductible
Inpatient substance use	Subject to $500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Covered at 80% per admission for unlimited days, subject to the deductible	Covered at 60% per admission for unlimited days, subject to the deductible	Covered at 80% per admission for unlimited days, subject to the deductible	Covered at 60% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible
Outpatient substance use	3 visits covered in full. Next visits covered at $15 copay per visit	Covered at 80%, subject to the deductible	3 visits covered in full. Next visits covered at $30 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Other Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Skilled nursing facility	Subject to $500 copay per admission for up to 200 days per year	Covered at 80%, per admission for up to 200 days per year, subject to the deductible	Covered at 80% per admission for 200 days per year, subject to the deductible	Covered at 60% per admission for 200 days per year, subject to the deductible	Covered at 80% per admission for 200 days per year, subject to the deductible	Covered at 60% per admission for 200 days per year, subject to the deductible	Covered at 100% per admission for 200 days per year, subject to the deductible	Covered at 100% per admission for 200 days per year, subject to the deductible
Home care	$15 copay per visit for 40 visits per year	Covered at 80%, for up to 40 visits per year, subject to the deductible	Covered at 80% for up to 40 visits per year, subject to the deductible	Covered at 60% for up to 40 visits per year, subject to the deductible	Covered at 80% for up to 40 visits per year, subject to the deductible	Covered at 60% for up to 40 visits per year, subject to the deductible	Covered at 100% for up to 40 visits per year, subject to the deductible	Covered at 100% for up to 40 visits per year, subject to the deductible
Hospice	Subject to $500 copay per admission for up to 210 days per year	Covered at 80%, for up to 210 days per year, subject to the deductible	Covered at 80% for up to 210 visits per year, subject to the deductible	Covered at 60% for up to 210 visits per year, subject to the deductible	Covered at 80% for up to 210 visits per year, subject to the deductible	Covered at 60% for up to 210 visits per year, subject to the deductible	Covered at 100% for up to 210 visits per year, subject to the deductible	Covered at 100% for up to 210 visits per year, subject to the deductible
Outpatient therapy	$25 per visit for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 80%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	$50 for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 60%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 80%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 60%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 100%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 100%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year
Durable medical equipment	Covered at 50%	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
External prosthetics	Covered at 50%	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Chiropractic	$15 copay per visit	Covered at 80%, subject to the deductible	$30 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Acupuncture	$25 copay per visit	Covered at 80%, subject to the deductible	$50 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Hearing Aids	Covered at 50% for a single purchase once every 3 years	Covered at 50%, subject to the deductible for a single purchase once every 3 years	Covered at 50% , subject to the deductible for a single purchase once every 3 years	Covered at 50%, subject to the deductible for a single purchase once every 3 years	Covered at 50% , subject to the deductible for a single purchase once every 3 years	Covered at 50%, subject to the deductible for a single purchase once every 3 years	Covered at 100% , subject to the deductible for a single purchase once every 3 years	Covered at 100%, subject to the deductible for a single purchase once every 3 years
Vision Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**

	SimplyBlue Plus Platinum 2		SimplyBlue Plus Gold 17		SimplyBlue Plus Silver 2		SimplyBlue Plus Bronze 4	
Adult Routine Vision Exam	One routine exam covered in full per year	Covered at 80% for one routine exam every year, subject to the deductible	One routine exam covered in full per year	Covered at 60% for one routine exam every year, subject to the deductible	One routine exam covered in full per year, subject to the deductible	Covered at 60% for one routine exam every year, subject to the deductible	One routine exam covered in full per year, subject to the deductible	Covered at 100% for one routine exam every year, subject to the deductible
Adult Diagnostic Vision	$25 copay per visit	Covered at 80%, subject to the deductible	$50 copay per visit	Covered at 60%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Adult Eyewear	Eyewear Reimbursement of $100 per year	Eyewear Reimbursement of $100 per year	Eyewear Reimbursement of $100 per year	Eyewear Reimbursement of $100 per year	Eyewear Reimbursement of $100 per year	Eyewear Reimbursement of $100 per year	Eyewear Reimbursement of $100 per year	Eyewear Reimbursement of $100 per year
Pediatric Routine Vision Exam	$25 copay per visit for one routine exam every year	Covered at 80% for one routine exam every year, subject to the deductible	$50 copay per visit for one routine exam every year	Covered at 60% for one routine exam every year, subject to the deductible	Covered at 80% for one routine exam every year, subject to the deductible	Covered at 60% for one routine exam every year, subject to the deductible	Covered at 100% for one routine exam every year, subject to the deductible	Covered at 100% for one routine exam every year, subject to the deductible
Pediatric Eyewear	Covered at 50% for one purchase per plan year	Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 50%, subject to the deductible for one purchase per plan year	Covered at 100%, subject to the deductible for one purchase per plan year	Covered at 100%, subject to the deductible for one purchase per plan year
Dental Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Preventive covered at 100%. Routine covered at 80%	Preventive covered at 100%, subject to balance billng. Routine covered at 80%,subject to the deductible and balance billing	Preventive covered at 100%. Routine covered at 80%, subject to the deductible	Preventive covered at 100%, subject to balance billing. Routine covered at 80%, subject to the deductible and balance billing	Preventive cleaning and exams not subject to the deductible. Preventive services covered at 100%, subject to the deductible. Routine services covered at 80%, subject to the deductible	Preventive cleaning and exams not subject to the deductible. Preventive services covered at 100%, subject to the deductible. Routine services covered at 80%, subject to the deductible and balance billing	Preventive cleaning and exams not subject to the deductible. Preventive services covered at 100%, subject to the deductible. Routine services covered at 100%, subject to the deductible	Preventive cleaning and exams not subject to the deductible. Preventive services covered at 100%, subject to the deductible. Routine services covered at 100%, subject to the deductible and balance billing
Pediatric Major Dental Care & Medical Ortho	Covered at 50%	Covered at 50%, subject to the deductible and balance billing	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible and balance billing	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible and balance billing	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible and balance billing
Accidental Dental - Outpatient Surgical	$150 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 60% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 60% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 100% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 100% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible