Excellus

Version Updated: 09/11/2022

Rating Region: Syracuse

	SimplyBlue Plus Gold 17		SimplyBlue Plus Gold 17	
Plan Overview				
Plan ID	78124NY0990249-00		78124NY0990249-00 (TWWZ)	
Plan Name	SimplyBlue Plus Gold 17		SimplyBlue Plus Gold 17	
Aggregation Design	Individual Aggregation		Individual Aggregation	
Plan Highlights	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 select covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full, includes Active&Fit ExerciseRewards.	
Plan Type	Hybrid		Hybrid	
HSA Eligible	No		No	
Quote Effective	01/01/2022 - 03/31/2022		01/01/2023 - 03/31/2023	
Rate ($)	**Small Group**		**Small Group**	
Single	$786.94		$841.59	
Subscriber & Spouse	$1,573.89		$1,683.17	
Subscriber & Child(ren)	$1,337.80		$1,430.69	
Family	$2,242.79		$2,398.52	
Plan features				
Primary Care Physician (PCP)	Not Required		Not Required	
Referrals	Not Required		Not Required	
Out of network benefits	Covered at 60%, subject to the deductible		Covered at 60%, subject to the deductible	
Out of area benefits	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	
Domestic partner	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: 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	Not Applicable		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 highlights				
Plan cost-sharing highlights	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Primary Care Office Visit	$30 copay per visit	Covered at 60%, subject to the deductible	$40 copay per visit	Covered at 60%, subject to the deductible

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Specialist Office Visit	$50 copay per visit	Covered at 60%, subject to the deductible	$60 copay per visit	Covered at 60%, subject to the deductible
Coinsurance	Covered at 80%	Covered at 60%	Covered at 80%	Covered at 60%
Deductible	In-Network: $1,000 Individual / $2,000 Family	Out-of-Network: $5,000 Individual / $10,000 Family	In-Network: $1,100 Individual / $2,200 Family	Out-of-Network: $5,000 Individual / $10,000 Family
Out of pocket maximum	$8,150 Individual / $16,300 Family	$10,000 Individual / $20,000 Family	$8,250 Individual / $16,500 Family	$10,000 Individual / $20,000 Family
Lifetime maximum	None	None	None	None
Plan Benefits				
Preventive Healthcare Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Well child visits	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
Adult routine physical exams	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
+Adult immunizations	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
+Mammography	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
+Pap smear	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
Routine GYN Exam	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
+Prostate cancer screening	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
+Colonoscopy	Preventive screenings covered in full	Covered at 60%, subject to the deductible	Preventive screenings covered in full	Covered at 60%, subject to the deductible
+Family Planning Services	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
Physician Office Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic Visits - In-Person or Virtual	$30 PCP copay; $50 Specialist copay per visit	Covered at 60%, subject to the deductible	$40 PCP copay; $60 Specialist copay per visit	Covered at 60%, subject to the deductible
Telemedicine with MDLive	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
Diagnostic x-rays	$50 copay per visit	Covered at 60%, subject to the deductible	$60 copay per visit	Covered at 60%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	Covered at 60%, subject to the deductible	$100 copay per visit	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	$30 copay per visit	Covered at 60%, subject to the deductible	$40 copay per visit	Covered at 60%, subject to the deductible
Allergy tests	$30 PCP copay; $50 Specialist copay per visit	Covered at 60%, subject to the deductible	$40 PCP copay; $60 Specialist copay per visit	Covered at 60%, subject to the deductible
Allergy injections	$30 PCP copay; $50 Specialist copay per visit	Covered at 60%, subject to the deductible	$40 PCP copay; $60 Specialist copay per visit	Covered at 60%, subject to the deductible
Chemotherapy	$30 copay per visit	Covered at 60%, subject to the deductible	$40 copay per visit	Covered at 60%, subject to the deductible
Radiation therapy	$50 copay per visit	Covered at 60%, subject to the deductible	$60 copay per visit	Covered at 60%, subject to the deductible
Maternity Services	**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 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
Hospital care for mom (including delivery)	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
Newborn nursery care	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
Prescription Drug	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**

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Prescription Drug Coverage	$10/$45/$90	Not Covered	$10/$45/$90	Not Covered
Diabetic drugs, insulin, and supplies	$30 copay per 30 day supply	Covered at 60%, subject to the deductible	$40 copay per 30 day supply	Covered at 60%, subject to the deductible
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital benefits	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
Physician visits in the hospital	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
Inpatient physical rehabilitation	Covered at 80% per 60 day stay per admission per contract year, subject to the deductible	Covered at 60% per 60 day stay per admission per contract year, subject to the deductible	Covered at 80% per 60 day stay per admission per contract year, subject to the deductible	Covered at 60% per 60 day stay per admission per contract year, subject to the deductible
Surgery	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
Anesthesia	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
Emergency Care	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency room care	$250 copay per visit	$250 copay per visit	$250 copay per visit	$250 copay per visit
Freestanding urgent care center	$50 copay per visit	Covered at 60%, subject to the deductible	$60 copay per visit	Covered at 60%, subject to the deductible
Ambulance	$250 copay per visit	$250 copay per visit	$250 copay per visit	$250 copay per visit
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic x-rays	$50 copay per visit	Covered at 60%, subject to the deductible	$60 copay per visit	Covered at 60%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	Covered at 60%, subject to the deductible	$100 copay per visit	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	$30 copay per visit	Covered at 60%, subject to the deductible	$40 copay per visit	Covered at 60%, subject to the deductible
Surgical Care Facility Fee	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
Chemotherapy	$30 copay per visit	Covered at 60%, subject to the deductible	$40 copay per visit	Covered at 60%, subject to the deductible
Radiation Therapy	$50 copay per visit	Covered at 60%, subject to the deductible	$60 copay per visit	Covered at 60%, subject to the deductible
Mental Health and Substance Use	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient mental health care	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
Outpatient mental health care	3 visits covered in full. Next visits covered at $30 copay per visit	Covered at 60%, subject to the deductible	3 visits covered in full. Next visits covered at $40 copay per visit	Covered at 60%, subject to the deductible
Inpatient substance use	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
Outpatient substance use	3 visits covered in full. Next visits covered at $30 copay per visit	Covered at 60%, subject to the deductible	3 visits covered in full. Next visits covered at $40 copay per visit	Covered at 60%, subject to the deductible
Other Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Skilled nursing facility	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
Home care	Covered at 80% for up to 40 visits per year,	Covered at 60% for up to 40 visits per year,	Covered at 80% for up to 40 visits per year,	Covered at 60% for up to 40 visits per year,

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	subject to the deductible	subject to the deductible	subject to the deductible	subject to the deductible
Hospice	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
Outpatient therapy	$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	$40 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
Durable medical equipment	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
External prosthetics	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
Chiropractic	$30 copay per visit	Covered at 60%, subject to the deductible	$40 copay per visit	Covered at 60%, subject to the deductible
Acupuncture	$50 copay per visit	Covered at 60%, subject to the deductible	$60 copay per visit	Covered at 60%, subject to the deductible
Hearing Aids	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
Vision Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Routine Vision Exam	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	Covered at 60% for one routine exam every year, subject to the deductible
Adult Diagnostic Vision	$50 copay per visit	Covered at 60%, subject to the deductible	$60 copay per visit	Covered at 60%, 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
Pediatric Routine Vision Exam	$50 copay per visit for one routine exam every year	Covered at 60% 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
Pediatric Eyewear	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
Dental Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	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 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
Pediatric Major Dental Care & Medical Ortho	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
Accidental Dental - Outpatient Surgical	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