**Version Updated: 10/28/2021**

**Rating Region: Rochester**

| | SimplyBlue Plus Gold 19 | | SimplyBlue Plus Gold 19 | |
|---|---|---|---|---|
| **Plan Overview** | | | | |
| Plan ID | 78124NY0990297-00 | | 78124NY0990297-00 (SYX1) | |
| Plan Name | SimplyBlue Plus Gold 19 | | SimplyBlue Plus Gold 19 | |
| 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 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 | 07/01/2021 - 09/30/2021 | | 07/01/2022 - 09/30/2022 | |
| **Rate ($)** | **Small Group** | | **Small Group** | |
| Single | $597.22 | | $651.35 | |
| Subscriber & Spouse | $1,194.44 | | $1,302.70 | |
| Subscriber & Child(ren) | $1,015.27 | | $1,107.30 | |
| Family | $1,702.08 | | $1,856.35 | |
| **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 BlueCardÂ® 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 | ExerciseRewardsÃ‚Â® receive up to $600 in rewards a year by visiting a qualified fitness facility and save on Gym memberships with Active&Fit DirectÃ¢â€žÂ¢. | | 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** |

| | SimplyBlue Plus Gold 19 | | SimplyBlue Plus Gold 19 | |
|---|---|---|---|---|
| Primary Care Office Visit | $40 copay per visit | Covered at 60%, subject to the deductible | $40 copay per visit | Covered at 60%, subject to the deductible |
| Specialist Office Visit | $60 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: $2,250 Individual / $4,500 Family | Out-of-Network: $5,000 Individual / $10,000 Family | In-Network: $2,250 Individual / $4,500 Family | Out-of-Network: $5,000 Individual / $10,000 Family |
| Out of pocket maximum | In-Network: $6,850 Individual / $13,700 Family | Out-of-Network: $10,000 Individual / $20,000 Family | $6,850 Individual / $13,700 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 office visits | $40 PCP copay; $60 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 and Telehealth Services | Covered in Full | Covered at 60%, subject to the deductible | Covered In Full | Covered at 60%, subject to the deductible |
| Diagnostic x-rays | $60 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 | $40 copay per visit | Covered at 60%, subject to the deductible | $40 copay per visit | Covered at 60%, subject to the deductible |
| Allergy tests | $40 PCP copay; $60 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 | $40 PCP copay; $60 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 | $40 copay per visit | Covered at 60%, subject to the deductible | $40 copay per visit | Covered at 60%, subject to the deductible |
| Radiation therapy | $60 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 |

| | SimplyBlue Plus Gold 19 | | SimplyBlue Plus Gold 19 | |
|---|---|---|---|---|
| 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** |
| Prescription Drug Coverage | $5/$45/$90 | Not Covered | $5/$45/$90 | Not Covered |
| Diabetic drugs, insulin, and supplies | $40 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 | $350 copay per visit | $350 copay per visit | $350 copay per visit | $350 copay per visit |
| Freestanding urgent care center | $60 copay per visit | Covered at 60%, subject to the deductible | $60 copay per visit | Covered at 60%, subject to the deductible |
| Ambulance | $350 copay per visit | $350 copay per visit | $350 copay per visit | $350 copay per visit |
| **Outpatient Hospital Benefits** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| Diagnostic x-rays | $60 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 | $40 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 | $40 copay per visit | Covered at 60%, subject to the deductible | $40 copay per visit | Covered at 60%, subject to the deductible |
| Radiation Therapy | $60 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 $40 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 $40 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 | Covered at 60% per admission for 200 days | Covered at 80% per admission for 200 days | Covered at 60% per admission for 200 days |

| | SimplyBlue Plus Gold 19 | | SimplyBlue Plus Gold 19 | |
|---|---|---|---|---|
| | per year, subject to the deductible | per year, subject to the deductible | per year, subject to the deductible | per year, subject to the deductible |
| Home care | 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 |
| 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 | $60 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 | $60 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 | $60 copay per visit | Covered at 60%, subject to the deductible | $40 copay per visit | Covered at 60%, subject to the deductible |
| Acupuncture | $60 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 | $60 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 |
| Adult Diagnostic Vision | $60 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 $60 per year | Eyewear Reimbursement of $60 per year | Eyewear Reimbursement of $100 per year | Eyewear Reimbursement of $100 per year |
| Pediatric Routine Vision Exam | $60 copay per visit for one routine exam every year | Covered at 60% for one routine exam every year, subject to the deductible | $60 copay per visit for one routine exam every 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 |