



Version Updated: 09/11/2022
 Rating Region: Syracuse

SimplyBlue Plus Gold 19		SimplyBlue Plus Gold 19	
Plan Overview			
Plan ID	78124NY0990297-00	78124NY0990297-00 (TYYP)	
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 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	\$733.32	\$801.24	
Subscriber & Spouse	\$1,466.64	\$1,602.48	
Subscriber & Child(ren)	\$1,246.64	\$1,362.11	
Family	\$2,089.97	\$2,283.54	
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/Dependant 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	Out-of-Network
Primary Care Office Visit	\$40 copay per visit	Covered at 60%, subject to the deductible	Covered at 60%, subject to the deductible

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Specialist Office Visit	\$60 copay per visit	Covered at 60%, subject to the deductible	Covered at 60%, subject to the deductible	\$60 copay per visit	Covered at 60%, subject to the deductible
Coinurance	Covered at 80%	Covered at 60%	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	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	\$6,850 Individual / \$13,700 Family	\$10,000 Individual / \$20,000 Family	\$10,000 Individual / \$20,000 Family	\$6,850 Individual / \$13,700 Family	\$10,000 Individual / \$20,000 Family
Lifetime maximum	None	None	None	None	None
Plan Benefits					
Preventive Healthcare Services					
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	\$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 with MD/ive	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	
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	\$5,\$45,\$90	Not Covered	\$5,\$45,\$90
Diabetic drugs, insulin, and supplies	\$40 copay per 30 day supply	Covered at 60%, subject to the deductible	\$40 copay per 30 day supply
Inpatient Hospital Benefits	In-Network	Out-of-Network	In-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
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
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
Surgery	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 80%, 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
Emergency Care	In-Network	Out-of-Network	In-Network
Emergency room care	\$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
Ambulance	\$350 copay per visit	\$350 copay per visit	\$350 copay per visit
Outpatient Hospital Benefits	In-Network	Out-of-Network	In-Network
Diagnostic x-rays	\$60 copay per visit	Covered at 60%, subject to the deductible	\$60 copay per visit
Advanced Imaging Services	\$100 copay per visit	Covered at 60%, subject to the deductible	\$100 copay per visit
Diagnostic laboratory and pathology	\$40 copay per visit	Covered at 60%, subject to the deductible	\$40 copay per visit
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
Chemotherapy	\$40 copay per visit	Covered at 60%, subject to the deductible	\$40 copay per visit
Radiation Therapy	\$60 copay per visit	Covered at 60%, subject to the deductible	\$60 copay per visit
Mental Health and Substance Use	In-Network	Out-of-Network	In-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
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
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
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
Other Services	In-Network	Out-of-Network	In-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
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,

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	subject to the deductible	subject to the deductible	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	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
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	\$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	\$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	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	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	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
Chiropractic	\$40 copay per visit	Covered at 60%, subject to the deductible	\$40 copay per visit	Covered at 60%, subject to the deductible	\$40 copay per visit	Covered at 60%, subject to the deductible	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	\$60 copay per visit	Covered at 60%, subject to the deductible	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	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	In-Network	Out-of-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	One routine exam covered in full per year	Covered at 60% for one routine exam every year, subject to the deductible	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	\$60 copay per visit	Covered at 60%, subject to the deductible	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	Eyewear. Reimbursement of \$100 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	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	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	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	In-Network	Out-of-Network	Out-of-Network
Adult Dental Care	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%, 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	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%, 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	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible and balance billing	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	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

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," "B," "C" or "D" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

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