



Version Updated : 09/11/2022

Rating Region: Syracuse

SimplyBlue Plus Platinum 6		SimplyBlue Plus Platinum 6	
Plan Overview			
Plan ID	78124NY0980185-00	78124NY0980185-00 (TXXP)	
Plan Name	SimplyBlue Plus Platinum 6	SimplyBlue Plus Platinum 6	
Aggregation Design	Individual Aggregation	Individual Aggregation	
Plan Highlights	Predictable out-of-pocket costs without a deductible, includes Active&Fit ExerciseRewards.	Predictable out-of-pocket costs without a deductible, includes Active&Fit ExerciseRewards.	
Plan Type	Copay	Copay	
HSA Eligible	No	No	
Quote Effective	01/01/2022 - 03/31/2022	01/01/2023 - 03/31/2023	
Rate (\$)	Small Group	Small Group	
Single	\$931.49	\$1,018.37	
Subscriber & Spouse	\$1,862.98	\$2,036.74	
Subscriber & Child(ren)	\$1,583.53	\$1,731.23	
Family	\$2,654.75	\$2,902.35	
Plan features			
Primary Care Physician (PCP)	Not Required	Not Required	
Referrals	Not Required	Not Required	
Out of network benefits	Covered at 80%, subject to the deductible	Covered at 80%, 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	Out-of-Network
Primary Care Office Visit	\$30 copay per visit	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible
Specialist Office Visit	\$50 copay per visit	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible

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Coinsurance	None	Covered at 80%	None
Deductible	None	Out-of-Network: \$5,000 Individual / \$10,000 Family	None
Out of pocket maximum	\$6,550 Individual / \$13,100 Family	\$10,000 Individual / \$20,000 Family	\$6,550 Individual / \$13,100 Family
Lifetime maximum	None	None	None
Plan Benefits			
Preventive Healthcare Services	In-Network	Out-of-Network	In-Network
Well child visits	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full
Adult routine physical exams	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full
+Adult immunizations	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full
+Mammography	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full
+Pap smear	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full
Routine GYN Exam	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full
+Prostate cancer screening	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full
+Colonoscopy	Preventive screenings covered in full	Covered at 80%, subject to the deductible	Preventive screenings covered in full
+Family Planning Services	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full
Physician Office Services	In-Network	Out-of-Network	In-Network
Diagnostic Visits - In-Person or Virtual	\$30 PCP copay; \$50 Specialist copay per visit	Covered at 80%, subject to the deductible	\$30 PCP copay; \$50 Specialist copay per visit
Telemedicine with MD/ Live	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full
Diagnostic x-rays	\$50 copay per visit	Covered at 80%, subject to the deductible	\$50 copay per visit
Advanced Imaging Services	\$100 copay per visit	Covered at 80%, subject to the deductible	\$100 copay per visit
Diagnostic laboratory and pathology	\$30 copay per visit	Covered at 80%, subject to the deductible	\$30 copay per visit
Allergy tests	\$30 PCP copay; \$50 Specialist copay per visit	Covered at 80%, subject to the deductible	\$30 PCP copay; \$50 Specialist copay per visit
Allergy injections	\$30 PCP copay; \$50 Specialist copay per visit	Covered at 80%, subject to the deductible	\$30 PCP copay; \$50 Specialist copay per visit
Chemotherapy	\$30 copay per visit	Covered at 80%, subject to the deductible	\$30 copay per visit
Radiation therapy	\$50 copay per visit	Covered at 80%, subject to the deductible	\$50 copay per visit
Maternity Services	In-Network	Out-of-Network	In-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)
Hospital care for mom (including delivery)	Subject to \$750 copay per admission	Covered at 80%, per admission, subject to the deductible	Subject to \$750 copay per admission
Newborn nursery care	Covered In Full	Covered at 80%, per admission, subject to the deductible	Covered In Full
Prescription Drug	In-Network	Out-of-Network	In-Network

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Prescription Drug Coverage	\$5/\$35/\$70	Not Covered	\$5/\$35/\$70
Diabetic drugs, insulin, and supplies	\$30 copay per 30 day supply	Covered at 80%, subject to the deductible	\$30 copay per 30 day supply
Inpatient Hospital Benefits	In-Network	Out-of-Network	In-Network
Hospital benefits	Subject to \$750 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to \$750 copay per admission for unlimited days
Physician visits in the hospital	Covered In Full	Covered at 80%, subject to the deductible per admission	Covered In Full
Inpatient physical rehabilitation	Subject to \$750 copay per admission for up to 60 days per contract year	Covered at 80%, per admission for up to 60 days per contract year, subject to the deductible	Subject to \$750 copay per admission for up to 60 days per contract year
Surgery	Covered In Full	Covered at 80%, subject to the deductible per admission	Covered In Full
Anesthesia	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full
Emergency Care	In-Network	Out-of-Network	In-Network
Emergency room care	\$250 copay per visit	\$250 copay per visit	\$250 copay per visit
Frees-standing urgent care center	\$50 copay per visit	Covered at 80%, subject to the deductible	\$50 copay per visit
Ambulance	\$250 copay	\$250 copay	\$250 copay
Outpatient Hospital Benefits	In-Network	Out-of-Network	In-Network
Diagnostic x-rays	\$50 copay per visit	Covered at 80%, subject to the deductible	\$50 copay per visit
Advanced Imaging Services	\$100 copay per visit	Covered at 80%, subject to the deductible	\$100 copay per visit
Diagnostic laboratory and pathology	\$30 copay per visit	Covered at 80%, subject to the deductible	\$30 copay per visit
Surgical Care Facility Fee	\$250 copay per visit	Covered at 80%, subject to the deductible	\$250 copay per visit
Chemotherapy	\$30 copay per visit	Covered at 80%, subject to the deductible	\$30 copay per visit
Radiation Therapy	\$50 copay per visit	Covered at 80%, subject to the deductible	\$50 copay per visit
Mental Health and Substance Use	In-Network	Out-of-Network	In-Network
Inpatient mental health care	Subject to \$750 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to \$750 copay per admission for unlimited days
Outpatient mental health care	3 visits covered in full. Next visits covered at \$30 copay per visit	Covered at 80%, subject to the deductible	3 visits covered in full. Next visits covered at \$30 copay per visit
Inpatient substance use	Subject to \$750 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to \$750 copay per admission for unlimited days
Outpatient substance use	3 visits covered in full. Next visits covered at \$30 copay per visit	Covered at 80%, subject to the deductible	3 visits covered in full. Next visits covered at \$30 copay per visit
Other Services	In-Network	Out-of-Network	In-Network
Skilled nursing facility	Subject to \$750 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	Subject to \$750 copay per admission for up to 200 days per year

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Home care	\$30 copay per visit for 40 visits per year	Covered at 80%, for up to 40 visits per year, subject to the deductible	\$30 copay per visit for 40 visits per year, subject to the deductible
Hospice	Subject to \$750 copay per admission for up to 210 days per year	Covered at 80%, for up to 210 days per year, subject to the deductible	Subject to \$750 copay per admission for up to 210 days per year
Outpatient therapy	\$50 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	\$30 per visit 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
External prosthetics	Covered at 50%	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
Chiropractic	\$30 copay per visit	Covered at 80%, subject to the deductible	\$30 copay per visit
Acupuncture	\$50 copay per visit	Covered at 80%, subject to the deductible	\$50 copay per visit
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% for a single purchase once every 3 years
Vision Benefits	In-Network	Out-of-Network	In-Network
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
Adult Diagnostic Vision	\$50 copay per visit	Covered at 80%, subject to the deductible	\$50 copay per visit
Adult Eyewear	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 80% for one routine exam every year, subject to the deductible	One routine exam covered in full per year
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% for one purchase per plan year
Dental Benefits	In-Network	Out-of-Network	In-Network
Adult Dental Care	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 billing. Routine covered at 80%, subject to the deductible and balance billing	Preventive covered at 100%. Routine covered at 80%
Pediatric Major Dental Care & Medical Ortho	Covered at 50%	Covered at 50%, subject to the deductible and balance billing	Covered at 50%
Accidental Dental - Outpatient Surgical	\$250 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	\$250 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly

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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