Excellus

Quote Effective: 04/01/2023 - 06/30/2023

Version Updated: 09/11/2022

Print Package: HIOS ID (Enrollment Code)	**78124NY1000266-00 (TZZM)**
Plan Name:	**SimplyBlue Plus Silver 17**
Rating Region:	**Syracuse**
Rate	
For the Benefits described in the Agreement, the Plan will charge and Group will pay the following premium rates:	
Single	$677.77
Subscriber & Spouse	$1,355.54
Subscriber & Child(ren)	$1,152.21
Family	$1,931.64
Dependent Coverage To Age **26**, Pediatric Dental Coverage **No**, 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 Silver 17	
Plan Overview		
Plan ID	78124NY1000266-00 (TZZM)	
Plan Name	SimplyBlue Plus Silver 17	
Aggregation Design	Family Aggregation	
Plan Highlights	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	Deductible HSA	
HSA Eligible	Yes	
Quote Effective	04/01/2023 - 06/30/2023	
Plan features		
Primary Care Physician (PCP)	Not Required	
Referrals	Not Required	
Out of network benefits	Covered at 60%, subject to the deductible	
Out of area benefits	Coverage provided worldwide through our BlueCard® Network	
Student/Dependent coverage	Qualified dependents are covered to age 26	
Domestic partner	Covered	
Wellness Incentives	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	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**
Primary Care Office Visit	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Specialist Office Visit	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Coinsurance	Covered at 80%	Covered at 60%
Deductible	In-Network: $3,600 Individual / $7,200 Family	Out-of-Network: $5,000 Individual / $10,000 Family
Out of pocket maximum	$6,550 Individual / $13,100 Family	$10,000 Individual / $20,000 Family
Lifetime maximum	None	None
Plan Benefits		
Preventive Healthcare Services	**In-Network**	**Out-of-Network**
Well child visits	Covered In Full	Covered at 60%, subject to the deductible
Adult routine physical exams	Covered In Full	Covered at 60%, subject to the deductible
+Adult immunizations	Covered In Full	Covered at 60%, subject to the deductible
+Mammography	Covered In Full	Covered at 60%, subject to the deductible
+Pap smear	Covered In Full	Covered at 60%, subject to the deductible
Routine GYN Exam	Covered In Full	Covered at 60%, subject to the deductible

	SimplyBlue Plus Silver 17	
+Prostate cancer screening	Covered In Full	Covered at 60%, subject to the deductible
+Colonoscopy	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
Physician Office Services	**In-Network**	**Out-of-Network**
Diagnostic Visits - In-Person or Virtual	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Telemedicine with MDLive	Covered In Full, subject to deductible	Covered at 60%, subject to the deductible
Diagnostic x-rays	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Advanced Imaging Services	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Allergy tests	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Allergy injections	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Chemotherapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Radiation therapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Maternity Services	**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
Hospital care for mom (including delivery)	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
Prescription Drug	**In-Network**	**Out-of-Network**
Prescription Drug Coverage	$5/$35/$70, 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	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Inpatient Hospital Benefits	**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
Physician visits in the hospital	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
Surgery	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
Emergency Care	**In-Network**	**Out-of-Network**
Emergency room care	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible
Freestanding urgent care center	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Ambulance	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible

	SimplyBlue Plus Silver 17	
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Diagnostic x-rays	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Advanced Imaging Services	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	Covered at 80%, subject to the deductible	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
Chemotherapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Radiation Therapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Mental Health and Substance Use	**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
Outpatient mental health care	Covered at 80%, subject to the deductible	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
Outpatient substance use	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Other Services	**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
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
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
Outpatient therapy	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
Durable medical equipment	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
Chiropractic	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Acupuncture	Covered at 80%, 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
Vision Benefits	**In-Network**	**Out-of-Network**
Adult Routine Vision Exam	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
Adult Diagnostic Vision	Covered at 80%, 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
Pediatric Routine Vision Exam	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
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
Dental Benefits	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Not Covered	Not Covered

	SimplyBlue Plus Silver 17	
Pediatric Major Dental Care & Medical Ortho	Not Covered	Not Covered
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

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.