Version Updated: 10/28/2021

Rating Region: Rochester

	SimplyBlue Plus Silver 18		SimplyBlue Plus Silver 18	
Plan Overview				
Plan ID	78124NY0990313-00		78124NY0990313-00 (SZD5)	
Plan Name	SimplyBlue Plus Silver 18		SimplyBlue Plus Silver 18	
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	10/01/2021 - 12/31/2021		10/01/2022 - 12/31/2022	
Rate ($)	**Small Group**		**Small Group**	
Single	$448.99		$490.33	
Subscriber & Spouse	$897.98		$980.66	
Subscriber & Child(ren)	$763.28		$833.56	
Family	$1,279.62		$1,397.44	
Plan features				
Primary Care Physician (PCP)	Not Required		Not Required	
Referrals	Not Required		Not Required	
Out of network benefits	Covered at 50%, subject to the deductible		Covered at 100%, 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	ExerciseRewards receive up to $600 in rewards a year by visiting a qualified fitness facility and save on Gym memberships with Active&Fit Direct.		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**

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Primary Care Office Visit	$50 copay per visit	Covered at 50%, subject to the deductible	$50 copay per visit	Covered at 100%, subject to the deductible
Specialist Office Visit	$75 copay per visit	Covered at 50%, subject to the deductible	$75 copay per visit	Covered at 100%, subject to the deductible
Coinsurance	Covered at 70%	Covered at 50%	Covered at 70%	Covered at 100%
Deductible	In-Network: $7,500 Individual / $15,000 Family	Out-of-Network: $10,000 Individual / $20,000 Family	In-Network: $7,500 Individual / $15,000 Family	Out-of-Network: $10,000 Individual / $20,000 Family
Out of pocket maximum	In-Network: $8,250 Individual / $16,500 Family	Out-of-Network: $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 50%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
Adult routine physical exams	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
+Adult immunizations	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
+Mammography	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
+Pap smear	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
Routine GYN Exam	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
+Prostate cancer screening	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
+Colonoscopy	Preventive screenings covered in full	Covered at 50%, subject to the deductible	Preventive screenings covered in full	Covered at 100%, subject to the deductible
+Family Planning Services	Covered in full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
Physician Office Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic office visits	$50 PCP copay; $75 Specialist copay per visit	Covered at 50%, subject to the deductible	$50 PCP copay; $75 Specialist copay per visit	Covered at 100%, subject to the deductible
Telemedicine and Telehealth Services	Covered in Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 100%, subject to the deductible
Diagnostic x-rays	$75 copay per visit	Covered at 50%, subject to the deductible	$75 copay per visit	Covered at 100%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	Covered at 50%, subject to the deductible	$100 copay per visit	Covered at 100%, subject to the deductible
Diagnostic laboratory and pathology	$50 copay per visit	Covered at 50%, subject to the deductible	$50 copay per visit	Covered at 100%, subject to the deductible
Allergy tests	$50 PCP copay; $75 Specialist copay per visit	Covered at 50%, subject to the deductible	$50 PCP copay; $75 Specialist copay per visit	Covered at 100%, subject to the deductible
Allergy injections	$50 PCP copay; $75 Specialist copay per visit	Covered at 50%, subject to the deductible	$50 PCP copay; $75 Specialist copay per visit	Covered at 100%, subject to the deductible
Chemotherapy	$50 copay per visit	Covered at 50%, subject to the deductible	$50 copay per visit	Covered at 100%, subject to the deductible
Radiation therapy	$75 copay per visit	Covered at 50%, subject to the deductible	$75 copay per visit	Covered at 100%, 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 50%, subject to the deductible	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered at 100%, subject to the deductible
Hospital care for mom (including delivery)	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 100%, subject to the deductible

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Newborn nursery care	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 100%, subject to the deductible
Prescription Drug	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Coverage	$10/40%/50%	Not Covered	$10/40%/50%	Not Covered
Diabetic drugs, insulin, and supplies	$50 copay per 30 day supply	Covered at 50%, subject to the deductible	$50 copay per 30 day supply	Covered at 100%, subject to the deductible
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital benefits	Covered at 70% per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible	Covered at 70% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible
Physician visits in the hospital	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 100%, subject to the deductible
Inpatient physical rehabilitation	Covered at 70% per 60 day stay per admission per contract year, subject to the deductible	Covered at 50% per 60 day stay per admission per contract year, subject to the deductible	Covered at 70% per 60 day stay per admission per contract year, subject to the deductible	Covered at 100% per 60 day stay per admission per contract year, subject to the deductible
Surgery	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 100%, subject to the deductible
Anesthesia	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 100%, subject to the deductible
Emergency Care	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency room care	$650 copay per visit	$650 copay per visit	$650 copay per visit	$650 copay per visit
Freestanding urgent care center	$75 copay per visit	Covered at 50%, subject to the deductible	$75 copay per visit	Covered at 100%, subject to the deductible
Ambulance	$650 copay per visit	$650 copay per visit	$650 copay per visit	$650 copay per visit
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic x-rays	$75 copay per visit	Covered at 50%, subject to the deductible	$75 copay per visit	Covered at 100%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	Covered at 50%, subject to the deductible	$100 copay per visit	Covered at 100%, subject to the deductible
Diagnostic laboratory and pathology	$50 copay per visit	Covered at 50%, subject to the deductible	$50 copay per visit	Covered at 100%, subject to the deductible
Surgical Care Facility Fee	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 70%, subject to the deductible	Covered at 100%, subject to the deductible
Chemotherapy	$50 copay per visit	Covered at 50%, subject to the deductible	$50 copay per visit	Covered at 100%, subject to the deductible
Radiation Therapy	$75 copay per visit	Covered at 50%, subject to the deductible	$75 copay per visit	Covered at 100%, 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 70% per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible	Covered at 70% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible
Outpatient mental health care	3 visits covered in full. Next visits covered at $50 copay per visit	Covered at 50%, subject to the deductible	3 visits covered in full. Next visits covered at $50 copay per visit	Covered at 100%, subject to the deductible
Inpatient substance use	Covered at 70% per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible	Covered at 70% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible
Outpatient substance use	3 visits covered in full. Next visits covered at $50 copay per visit	Covered at 50%, subject to the deductible	3 visits covered in full. Next visits covered at $50 copay per visit	Covered at 100%, subject to the deductible
Other Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**

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Skilled nursing facility	Covered at 70% per admission for 200 days per year, subject to the deductible	Covered at 50% per admission for 200 days per year, subject to the deductible	Covered at 70% per admission for 200 days per year, subject to the deductible	Covered at 100% per admission for 200 days per year, subject to the deductible
Home care	Covered at 70% for up to 40 visits per year, subject to the deductible	Covered at 50% for up to 40 visits per year, subject to the deductible	Covered at 70% for up to 40 visits per year, subject to the deductible	Covered at 100% for up to 40 visits per year, subject to the deductible
Hospice	Covered at 70% for up to 210 visits per year, subject to the deductible	Covered at 50% for up to 210 visits per year, subject to the deductible	Covered at 70% for up to 210 visits per year, subject to the deductible	Covered at 100% for up to 210 visits per year, subject to the deductible
Outpatient therapy	$75 for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 50%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	$75 for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 100%, 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	$75 copay per visit	Covered at 50%, subject to the deductible	$50 copay per visit	Covered at 100%, subject to the deductible
Acupuncture	$75 copay per visit	Covered at 50%, subject to the deductible	$75 copay per visit	Covered at 100%, 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	$75 copay per visit for one routine exam every year	Covered at 50% for one routine exam every year, subject to the deductible	One routine exam covered in full per year	Covered at 100% for one routine exam every year, subject to the deductible
Adult Diagnostic Vision	$75 copay per visit	Covered at 50%, subject to the deductible	$75 copay per visit	Covered at 100%, 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	$75 copay per visit for one routine exam every year	Covered at 50% for one routine exam every year, subject to the deductible	$75 copay per visit for one routine exam every year	Covered at 100% 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 70% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 50% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 70% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 100% 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.

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