Version Updated: 10/28/2021

Rating Region: Utica

	SimplyBlue Plus Silver 6		SimplyBlue Plus Silver 6	
Plan Overview				
Plan ID	78124NY0990105-00		78124NY0990105-00 (SYH1)	
Plan Name	SimplyBlue Plus Silver 6		SimplyBlue Plus Silver 6	
Aggregation Design	Individual Aggregation		Individual Aggregation	
Plan Highlights	A deductible is applied to all covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full. Plan includes ExerciseRewards.		A deductible is applied to all covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full. Plan 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	$664.94		$725.71	
Subscriber & Spouse	$1,329.88		$1,451.42	
Subscriber & Child(ren)	$1,130.40		$1,233.71	
Family	$1,895.08		$2,068.27	
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 50%, 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	$40 copay per visit, subject to deductible	Covered at 50%, subject to the deductible	$40 copay per visit, subject to deductible	Covered at 50%, subject to the deductible
Specialist Office Visit	$60 copay per visit, subject to deductible	Covered at 50%, subject to the deductible	$60 copay per visit, subject to deductible	Covered at 50%, subject to the deductible
Coinsurance	Covered at 75%	Covered at 50%	Covered at 75%	Covered at 50%
Deductible	In-Network: $2,500 Individual / $5,000 Family	Out-of-Network: $5,000 Individual / $10,000 Family	In-Network: $2,500 Individual / $5,000 Family	Out-of-Network: $5,000 Individual / $10,000 Family
Out of pocket maximum	In-Network: $8,000 Individual / $16,000 Family	Out-of-Network: $10,000 Individual / $20,000 Family	$8,000 Individual / $16,000 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 50%, subject to the deductible
Adult routine physical exams	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible
+Adult immunizations	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible
+Mammography	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible
+Pap smear	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible
Routine GYN Exam	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible
+Prostate cancer screening	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible
+Colonoscopy	Preventive screenings covered in full	Covered at 50%, subject to the deductible	Preventive screenings covered in full	Covered at 50%, subject to the deductible
+Family Planning Services	Covered in full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, 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, subject to deductible	Covered at 50%, subject to the deductible	$40 PCP copay; $60 Specialist copay per visit, subject to deductible	Covered at 50%, subject to the deductible
Telemedicine and Telehealth Services	Covered in full, subject to the deductible	Covered at 50%, subject to the deductible	Covered In Full, subject to deductible	Covered at 50%, subject to the deductible
Diagnostic x-rays	$60 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	$60 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Advanced Imaging Services	$100 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	$100 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Diagnostic laboratory and pathology	$40 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	$40 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Allergy tests	$40 PCP copay; $60 Specialist copay per visit, subject to deductible	Covered at 50%, subject to the deductible	$40 PCP copay; $60 Specialist copay per visit, subject to deductible	Covered at 50%, subject to the deductible
Allergy injections	$40 PCP copay; $60 Specialist copay per visit, subject to deductible	Covered at 50%, subject to the deductible	$40 PCP copay; $60 Specialist copay per visit, subject to deductible	Covered at 50%, subject to the deductible
Chemotherapy	$40 PCP copay per visit, subject to deductible	Covered at 50%, subject to the deductible	$40 PCP copay per visit, subject to deductible	Covered at 50%, subject to the deductible
Radiation therapy	$60 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	$60 copay per visit, subject to the deductible	Covered at 50%, 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 50%, subject to the deductible

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Hospital care for mom (including delivery)	Covered at 75%, subject to the deductible	Covered at 50% per admission, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50% per admission, subject to the deductible
Newborn nursery care	Covered In Full, subject to deductible	Covered at 50% per admission, subject to the deductible	Covered In Full, subject to deductible	Covered at 50% per admission, 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, subject to deductible per 30 day supply	Covered at 50%, subject to the deductible	$40 copay, subject to deductible per 30 day supply	Covered at 50%, subject to the deductible
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital benefits	Covered at 75% per admission for unlimited days, subject to the deductible	Covered at 50%, per admission for unlimited days, subject to the deductible	Covered at 75% per admission for unlimited days, subject to the deductible	Covered at 50%, per admission for unlimited days, subject to the deductible
Physician visits in the hospital	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible
Inpatient physical rehabilitation	Covered at 75% per 60 day stay per admission per contract year, subject to the deductible	Covered at 50% per admission for up to 60 days per contract year, subject to the deductible	Covered at 75% per 60 day stay per admission per contract year, subject to the deductible	Covered at 50% per admission for up to 60 days per contract year, subject to the deductible
Surgery	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible
Anesthesia	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible
Emergency Care	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency room care	$350 copay per visit, subject to deductible	$350 copay per visit, subject to deductible	$350 copay per visit, subject to deductible	$350 copay per visit, subject to deductible
Freestanding urgent care center	$60 copay per visit, subject to deductible	Covered at 50%, subject to the deductible	$60 copay per visit, subject to deductible	Covered at 50%, subject to the deductible
Ambulance	$350 copay per visit, subject to deductible	$350 copay per visit, subject to deductible	$350 copay per visit, subject to deductible	$350 copay per visit, subject to deductible
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic x-rays	$60 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	$60 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Advanced Imaging Services	$100 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	$100 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Diagnostic laboratory and pathology	$40 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	$40 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Surgical Care Facility Fee	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible
Chemotherapy	$40 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	$40 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Radiation Therapy	$60 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	$60 copay per visit, subject to the deductible	Covered at 50%, 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 75% per admission for unlimited days, subject to the deductible	Covered at 50%, per admission for unlimited days, subject to the deductible	Covered at 75% per admission for unlimited days, subject to the deductible	Covered at 50%, 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, subject to the deductible	Covered at 50%, subject to the deductible	3 visits covered in full. Next visits covered at $40 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Inpatient substance use	Covered at 75% per admission for unlimited days, subject to the deductible	Covered at 50%, per admission for unlimited days, subject to the deductible	Covered at 75% per admission for unlimited days, subject to the deductible	Covered at 50%, per admission for unlimited days, subject to the deductible

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Outpatient substance use	3 visits covered in full. Next visits covered at $40 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	3 visits covered in full. Next visits covered at $40 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Other Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Skilled nursing facility	Covered at 75% per admission for 200 days per year, subject to the deductible	Covered at 50% per admission for up to 200 days per year, subject to the deductible	Covered at 75% per admission for 200 days per year, subject to the deductible	Covered at 50% per admission for up to 200 days per year, subject to the deductible
Home care	$40 copay per visit for 40 visits per year, subject to the deductible	Covered at 50% for up to 40 visits per year, subject to the deductible	$40 copay per visit for 40 visits per year, subject to the deductible	Covered at 50% for up to 40 visits per year, subject to the deductible
Hospice	Covered at 75% 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 75% 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
Outpatient therapy	$60 per visit, subject to deductible 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	$60 per visit, subject to deductible 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
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, subject to the deductible	Covered at 50%, subject to the deductible	$40 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Acupuncture	$60 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	$60 copay per visit, subject to the deductible	Covered at 50%, 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, subject to deductible	Covered at 50% for one routine exam every year, subject to the deductible	One routine exam covered in full per year, subject to the deductible	Covered at 50% for one routine exam every year, subject to the deductible
Adult Diagnostic Vision	$60 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible	$60 copay per visit, subject to the deductible	Covered at 50%, 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, subject to deductible	Covered at 50% for one routine exam every year, subject to the deductible	$60 copay per visit for one routine exam every year, subject to deductible	Covered at 50% 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 75% 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 75% 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