

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

Version Updated: 09/11/2022

Print Package: HIOS ID (Enrollment Code)	78124NY1000202-00 (TVVE)		
Plan Name:	SimplyBlue Plus Bronze 5		
Rating Region:	Utica		
Rate			
For the Benefits described in the Agreement, the Plan will ch	arge and Group will pay the following premium rates:		
Single	\$603.89		
Subscriber & Spouse	\$1,207.78		
Subscriber & Child(ren)	\$1,026.61		
Family	\$1,721.09		
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.			
	e 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. Iuding 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.			
Yes No B.) If you answered 'yes', please provide the name of the compan	CBS, that provides essential pediatric dental benefits through a NY State of Health certified dental plan? y issuing the essential pediatric dental coverage		

Signature: _

Total Employees:

Date:

Total Eligible:

Group Name:

Title:

Coverage Effective Date:

Broker:

	SimplyBlue Plus Bronze 5		
Plan Overview			
Plan ID	78124NY1000202-00 (TVVE)		
Plan Name	SimplyBlue Plus Bronze 5		
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 100%, 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 highligh	hts		
Plan cost-sharing highlights	In-Network	Out-of-Network	
Primary Care Office Visit	\$40 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	
Specialist Office Visit	\$60 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	
Coinsurance	Covered at 100%	Covered at 100%	
Deductible	In-Network: \$6,000 Individual / \$12,000 Family	Out-of-Network: \$10,000 Individual / \$20,000 Family	
Out of pocket maximum	\$7,500 Individual / \$15,000 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 100%, subject to the deductible	
Adult routine physical exams	Covered In Full	Covered at 100%, subject to the deductible	
+Adult immunizations	Covered In Full	Covered at 100%, subject to the deductible	
+Mammography	Covered In Full	Covered at 100%, subject to the deductible	
+Pap smear	Covered In Full	Covered at 100%, subject to the deductible	
Routine GYN Exam	Covered In Full	Covered at 100%, subject to the deductible	

	SimplyBlue Plus Bronze 5	
+Prostate cancer screening	Covered In Full	Covered at 100%, subject to the deductible
+Colonoscopy	Preventive screenings covered in full	Covered at 100%, subject to the deductible
+Family Planning Services	Covered In Full	Covered at 100%, subject to the deductible
Physician Office Services	In-Network	Out-of-Network
Diagnostic Visits - In-Person or Virtual	\$40 PCP copay; \$60 Specialist copay per visit, subject to deductible.	Covered at 100%, subject to the deductible
Telemedicine with MDLive	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible
Diagnostic x-rays	\$60 copay per visit, subject to deductible	Covered at 100%, subject to the deductible
Advanced Imaging Services	\$100 copay per visit, subject to the deductible	Covered at 100%, subject to the deductible
Diagnostic laboratory and pathology	\$40 copay per visit, subject to deductible	Covered at 100%, subject to the deductible
Allergy tests	\$40 PCP copay; \$60 Specialist copay per visit, subject to deductible	Covered at 100%, subject to the deductible
Allergy injections	\$40 PCP copay; \$60 Specialist copay per visit, subject to deductible	Covered at 100%, subject to the deductible
Chemotherapy	\$40 PCP copay per visit, subject to deductible	Covered at 100%, subject to the deductible
Radiation therapy	\$60 PCP copay per visit, subject to deductible	Covered at 100%, 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 100%, subject to the deductible
Hospital care for mom (including delivery)	Subject to \$1,000 copay per admission, subject to the deductible	Covered at 100% per admission, subject to the deductible
Newborn nursery care	Covered In Full, subject to deductible	Covered at 100% per admission, subject to the deductible
Prescription Drug	In-Network	Out-of-Network
Prescription Drug Coverage	\$10/\$45/\$90, 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	\$40 copay, subject to deductible per 30 day supply	Covered at 100%, subject to the deductible
Inpatient Hospital Benefits	In-Network	Out-of-Network
Hospital benefits	Subject to \$1,000 copay 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 In Full, subject to deductible	Covered at 100%, subject to the deductible
Inpatient physical rehabilitation	Subject to \$1,000 copay per admission for up to 60 days per per contract year, subject to the deductible	Covered at 100% per admission for up to 60 days per contract year, subject to the deductible
Surgery	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible
Anesthesia	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible
Emergency Care	In-Network	Out-of-Network
Emergency room care	\$500 copay per visit, subject to deductible	\$500 copay per visit, subject to deductible
Freestanding urgent care center	\$60 copay per visit, subject to deductible	Covered at 100%, subject to the deductible
Ambulance	\$500 copay per visit, subject to deductible	\$500 copay per visit, subject to deductible

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equipmentCovered at 50%, subject to the deductibleCovered at 50%, subject to the deductibleExternal prostheticsCovered at 50%, subject to the deductibleCovered at 100%, subject to the deductibleChiropractic\$40 copay per visit, subject to deductibleCovered at 100%, subject to the deductibleAcupuncture\$60 copay per visit, subject to deductibleCovered at 100%, subject to the deductibleHearing AidsCovered at 50%, subject to the deductible for a single purchase once every 3 yearsCovered at 50%, subject to the deductible for a single purchase once every 3 yearsVision BenefitsIn-NetworkOut-of-NetworkAdult Routine Vision ExamOne routine exam covered in full per year, subject to the deductibleCovered at 100%, subject to the deductibleAdult EyewearEyewear Reimbursement of \$100 per yearEyewear Reimbursement of \$100 per yearEyewear Reimbursement of \$100 per year, subject to the deductiblePediatric Routine VisionCovered at 50%, subject to the deductible for one purchase per plan yearCovered at 100% for one routine exam every year, subject to the deductiblePediatric EyewearEyewear to the deductible for one purchase per plan yearCovered at 100% for one routine exam every year, subject to the deductiblePediatric EyewearCovered at 50%, subject to the deductible for one purchase per plan yearCovered at 100% for one routine exam every year, subject to the deductiblePediatric EyewearCovered at 50%, subject to the deductible for one purchase per plan yearCovered at 50%, subject to the deductiblePediatric EyewearNot CoveredNot CoveredNot Covered <tr< td=""><td>Outpatient therapy</td><td></td><td>Covered at 100%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year</td></tr<>	Outpatient therapy		Covered at 100%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year
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Accupuncture \$60 copay per visit, subject to deductible 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 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 100%, subject to the deductible Adult Diagnostic Vision \$60 copay per visit, subject to deductible Covered at 100%, subject to the deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Eyewear Reimbursement of \$100 per year Pediatric Routine Vision One routine exam covered in full per year, subject to the deductible Covered at 100% for one routine exam every year, subject to the deductible Pediatric Routine Vision One routine exam covered in full per year, subject to the deductible Covered at 100% for one routine exam every year, subject to the deductible Pediatric Routine Vision One routine exam covered in full per year, subject to the deductible Covered at 100% for one routine exam every year, subject to the deductible Pediatric Routine Vision One routine exam covered in full per year, subject to the deductible for one purchase per plan year Covered at 50%, subject to the deductible for one purchase per plan year Dental Ben	External prosthetics	Covered at 50%, 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 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 100% for one routine exam every year, subject to the deductible Adult Diagnostic Vision \$60 copay per visit, subject to deductible Covered at 100%, subject to the deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Eyewear Reimbursement of \$100 per year Pediatric Routine Vision One routine exam covered in full per year, subject to the deductible Covered at 100% for one routine exam every year, subject to the deductible Pediatric Routine Vision One routine exam covered in full per year, subject to the deductible 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 Dental Benefits In-Network Out-of-Network Adult Dental Care Not Covered Not Covered Pediatric Dental: Not Covered Not Covered	Chiropractic	\$40 copay per visit, subject to deductible	Covered at 100%, subject to the deductible
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 100% for one routine exam every year, subject to the deductible Adult Diagnostic Vision \$60 copay per visit, subject to deductible Covered at 100%, subject to the deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Eyewear Reimbursement of \$100 per year Pediatric Routine Vision One routine exam covered in full per year, subject to the deductible Covered at 100% for one routine exam every year, subject to the deductible Pediatric Routine Vision One routine exam covered in full per year, subject to the deductible 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 Dental Benefits In-Network Out-of-Network Adult Dental Care Not Covered Not Covered Pediatric Dental: Not Covered Not Covered	Acupuncture	\$60 copay per visit, subject to deductible	Covered at 100%, subject to the deductible
Adult Routine Vision ExamOne routine exam covered in full per year, subject to the deductibleCovered at 100% for one routine exam every year, subject to the deductibleAdult Diagnostic Vision\$60 copay per visit, subject to deductibleCovered at 100%, subject to the deductibleAdult EyewearEyewear Reimbursement of \$100 per yearEyewear Reimbursement of \$100 per yearPediatric Routine Vision ExamOne routine exam covered in full per year, subject to the deductibleCovered at 100% for one routine exam every year, subject to the deductiblePediatric EyewearCovered at 50%, subject to the deductible for one purchase per plan yearCovered at 50%, subject to the deductible for one purchase per plan yearDental BenefitsIn-NetworkOut-of-NetworkAdult Dental CareNot CoveredNot CoveredPediatric Dental:Not CoveredNot Covered	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
Adult Diagnostic Vision \$60 copay per visit, subject to deductible Covered at 100%, subject to the deductible Adult Eyewear Eyewear Reimbursement of \$100 per year Eyewear Reimbursement of \$100 per year Pediatric Routine Vision One routine exam covered in full per year, subject to the deductible 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 Dental Benefits In-Network Out-of-Network Adult Dental Care Not Covered Not Covered Pediatric Dental: Not Covered Not Covered	Vision Benefits	In-Network	Out-of-Network
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Pediatric Routine Vision Exam One routine exam covered in full per year, subject to the deductible 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 Dental Benefits In-Network Out-of-Network Adult Dental Care Not Covered Not Covered Pediatric Dental: Not Covered Not Covered	Adult Diagnostic Vision	\$60 copay per visit, subject to deductible	Covered at 100%, subject to the deductible
Exam Anti-Anti-Anti-Anti-Anti-Anti-Anti-Anti-	Adult Eyewear	Eyewear Reimbursement of \$100 per year	Eyewear Reimbursement of \$100 per year
Dental Benefits In-Network Out-of-Network Adult Dental Care Not Covered Not Covered Pediatric Dental: Not Covered Not Covered		One routine exam covered in full per year, subject to the deductible	Covered at 100% for one routine exam every year, subject to the deductible
Adult Dental Care Not Covered Pediatric Dental: Not Covered	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
Pediatric Dental: Not Covered Not Covered	Dental Benefits	In-Network	Out-of-Network
	Adult Dental Care	Not Covered	Not Covered
Preventative & Routine	Pediatric Dental: Preventative & Routine	Not Covered	Not Covered

	SimplyBlue Plus Bronze 5	
Pediatric Major Dental Care & Medical Ortho	Not Covered	Not Covered
		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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