

Quote Effective: 10/01/2023 - 12/31/2023

Version Updated: 09/11/2022

Broker:

Print Package: HIOS ID (Enrollment Code)	78124NY1000314-00 (TAF1)				
Plan Name:	SimplyBlue Plus Gold 21				
Rating Region:	Utica				
Rate					
For the Benefits described in the Agreement, the Plan will cha	rge and Group will pay the following premium rate				
Single	\$904.63				
Subscriber & Spouse	\$1,809.26				
Subscriber & Child(ren)	\$1,537.87				
Family	\$2,578.20				
Dependent Coverage To Age 26, Pediatric Dental Coverage No, D	omestic Partner Coverage <b>Yes</b> , Family Planning Cove	age <b>Yes</b>			
Rates quoted herein are subject to change due to our implementat	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 answered 'no' please be aware the ACA requires essential pediatric dental coverage.  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:					

	SimplyBlue Plus Gold 21				
Plan Overview					
Plan ID	78124NY1000314-00 (TAF1)				
Plan Name	SimplyBlue Plus Gold 21				
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	10/01/2023 - 12/31/2023				
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 highligh	nts				
Plan cost-sharing highlights	In-Network	Out-of-Network			
Primary Care Office Visit	\$25 copay per visit, subject to deductible	Covered at 60%, subject to the deductible			
Specialist Office Visit	\$40 copay per visit, subject to deductible	Covered at 60%, subject to the deductible			
Coinsurance	Covered at 100%	Covered at 60%			
Deductible	In-Network: \$2,000 Individual / \$4,000 Family	Out-of-Network: \$5,000 Individual / \$10,000 Family			
Out of pocket maximum	\$5,500 Individual / \$11,000 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 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 Gold 21	
+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	\$25 PCP copay; \$40 Specialist copay per visit, subject to 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	\$40 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Advanced Imaging Services	\$100 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	\$25 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Allergy tests	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Allergy injections	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Chemotherapy	\$25 PCP copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Radiation therapy	\$40 PCP copay per visit, subject to 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)	Subject to \$500 copay per admission, subject to the deductible	Covered at 60% per admission, subject to the deductible
Newborn nursery care	Covered In Full, subject to deductible	Covered at 60% per admission, subject to the deductible
Prescription Drug	In-Network	Out-of-Network
Prescription Drug Coverage	\$5/\$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	\$25 copay, subject to deductible per 30 day supply	Covered at 60%, subject to the deductible
Inpatient Hospital Benefits	In-Network	Out-of-Network
Hospital benefits	Subject to \$500 copay 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 In Full, subject to deductible	Covered at 60%, subject to the deductible
Inpatient physical rehabilitation	Subject to \$500 copay per admission for up to 60 days per per contract year, subject to the deductible	Covered at 60% per admission for up to 60 days per contract year, subject to the deductible
Surgery	Covered In Full, subject to deductible	Covered at 60%, subject to the deductible
Anesthesia	Covered In Full, subject to deductible	Covered at 60%, subject to the deductible
Emergency Care	In-Network	Out-of-Network
Emergency room care	\$150 copay per visit, subject to deductible	\$150 copay per visit, subject to deductible
Freestanding urgent care center	\$40 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Ambulance	\$150 copay per visit, subject to deductible	\$150 copay per visit, subject to deductible

Experience   Control   C		SimplyBlue Plus Gold 21	
Diagnostic x-rays Advanced marging Services Services Diagnostic x-rays Services Diagnostic biboratory and Services Diagnostic biboratory and Services Diagnostic biboratory and Services Diagnostic biboratory and Services Surgical Case Facility Fee Services Surgical Case Facility Surgical Surgical Case Facility Surgical S		In-Network	Out-of-Network
Advanced maniphy Services  1500 copyay per visit, subject to the deductible  Covered at 60%, subject to the ded	Benefits		
Survices Disposation Education and pathology  Surgical Care Facility Fee Su	Diagnostic x-rays	\$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
pathology  Surgical Care Facility Fee Surgical Facility Fee Surgical Care F		\$100 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Chemotherapy \$25 copay per visit, subject to the deductible Covered at 60%, subject to the deductible Out-of-Network Out-of-Ne	,	\$25 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Rediation Therapy  S40 copay per visit, subject to the deductible  In-Network  Substance Use Inpatient mental health care  Outpoil mental health care  S25 copay per visit, subject to the deductible  Covered at 60%, subject to the deductible of physical, speech and occupational therapy for up 60 overed at 60%, subject to the deductible of physical, speech and occupational therapy for up 60 overed at 60%, subject to the deductible of physical, speech and occupational therapy for up 60 overed at 60%, subject to the	Surgical Care Facility Fee	\$150 copay per visit; subject to deductible	Covered at 60%, subject to the deductible
New	Chemotherapy	\$25 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Inpatient mental health care  Outpatient mental health care  Outpatient mental health care  Outpatient mental health care  Outpatient substance use  S25 copus per visit for 40 visits per year, subject to the deductible  Outpatient substance use  Outpatient flerapy  Subject to \$500 copay per admission for up to 200 days per year, subject to the deductible  Outpatient flerapy  S25 per visit for 40 visits per year, subject to the deductible  Outpatient flerapy  S25 per visit, subject to deductible for physical, speech and occupational therapy for up to 10 visits per contract year  Outpatient flerapy  S25 per visit, subject to deductible for physical, speech and occupational therapy for up to 10 visits per contract year  Outpatient flerapy  S25 per visit, subject to the deductible  Outpatient flerapy  S25 per visit, subject to the deductible  Outpatient flerapy  S25 per visit, subject to flerapy flera	Radiation Therapy	\$40 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Covered at 60%, subject to the deductible  Covered at 60%, subject to S00 copay per admission for up to 200 days per year, subject to the deductible  Covered at 60% per admission for up to 200 days per year, subject to the deductible  Covered at 60% for up to 200 days per year, subject to the deductible  Covered at 60% 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  Covered at 60% 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  Covered at 60%, subject to S00 copay per admission for up to 210 days per year, subject to the deductible  Covered at 60%, subject to S00 copay per admission for up to 210 days per year, subject to the deductible  Covered at 60%, subject to S00 copay per admission for up to 210 days per year, subject to the deductible  Covered at 60%, subject to S00 copay per admission for up to 210 days per year, subject to the deductible  Covered at 60%, subject to S00 copay per admission for up to 210 days per year, subject to the deductible  Covered at 60%, subject to S00 copay per admission for up to 210 days per year, subject to the deductible  Covered at 60%, subject to S00 copay per admission for up to 210 days per year, subject to the deductible  Covered at 50%, subject to S00 copay per admission for up to 210 days per year, subject to the deductible  Covered at 50%, subject to S00 copay per admission for up to 210 days per year, subject to the deductible  Covered at 50%, subject to the deductible  Covered at 5		In-Network	Out-of-Network
Inpatient substance use  Subject to \$500 copay per admission for unlimited days, subject to the deductible  Covered at 60%, subject to \$500 copay per admission for up to 200 days per year, subject to the deductible  Home care  \$25 copay per visit for 40 visits per year, subject to the deductible  Hospice  Subject to \$500 copay per admission for up to 200 days per year, subject to the deductible  Covered at 60%, 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  Covered at 60% 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  Covered at 60% 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  Covered at 60%, subject to the deductible covered at 60%, subject to the deductible covered at 60%, 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  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  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  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  Covered at 50%, subject to the deductible  Covered at 50%, subject to the deductible  Covered at 50%, subject to the deductible  Covered	'	Subject to \$500 copay per admission for unlimited days, subject to the deductible	Covered at 60% per admission for unlimited days, subject to the deductible
Outpatient substance use  Other Services  In-Network  Skilled nursing facility  Subject to \$500 copay per admission for up to 200 days per year, subject to the deductible  Covered at 60%, per admission for up to 200 days per year, subject to the deductible  Covered at 60% 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  Covered at 60% 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  Covered at 60% 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  Covered at 60% for up to 210 visits per year, subject to the deductible  Covered at 60% subject to \$500 copay per admission for up to 210 days per year, subject to the deductible  Covered at 60% subject to the deductible for physical, speech and occupational therapy for up to 210 visits per year, subject to the deductible  Covered at 50%, subject to the deductible for physical, speech and occupational therapy for up to 210 visits per contract year  Covered at 50%, subject to the deductible  Covered at 60%, subject to the deductib	•	\$25 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Content Services   In-Network   Skilled nursing facility   Subject to \$500 copay per admission for up to 200 days per year, subject to the deductible   Covered at 60%, for up to 200 days per year, subject to the deductible   Covered at 60%, 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   Covered at 60%, 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   Covered at 60%, 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   Covered at 60%, subject to the deductible   Covered at 50%, subject to the deductible   Covered at 60%, subject to the deductible   Cover	Inpatient substance use	Subject to \$500 copay per admission for unlimited days, subject to the deductible	Covered at 60% per admission for unlimited days, subject to the deductible
Skilled nursing facility  Subject to \$500 copay per admission for up to 200 days per year, subject to the deductible  Home care  \$25 copay per visit for 40 visits per year, subject to the deductible  Covered at 60%, for up to 20 visits per year, subject to the deductible  Covered at 60%, 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  Covered at 60%, for up to 210 visits per year, subject to the deductible  Covered at 60%, subject to the deductible for physical, speech and occupational therapy for up to 60  Visits per contract year  Durable medical equipment  External prosthetics  Covered at 50%, subject to the deductible  Covered at 60%, subject to the deductible  Covered at 50%, subject to the deductible  Covered at 50%, subject to the deductible  Covered at 60%, subject to the deductible  Covered at 60%, subject to the deductible  Covered at 50%, subject to the deductible  Covered at 50%, subject to the deductible  Covered at 60%, subject to the deductible for a single purchase once every 3 years  Covered at 60%, subject to the deductible for a single purchase once every 3 years  Covered at 60%, subject to the deductible for a single purchase once every 3 years  Covered at 60%, subject to the deductible for a single purchase once every 3 years  Covered at 60%, subject to the deductible for a single purchase once every 3 years  Covered at 60% for one routine exam every year, subject to the deductible  Adult Powers  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one rout	Outpatient substance use	\$25 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Home care  \$25 copay per visit for 40 visits per year, subject to the deductible  Covered at 60%. for up to 40 visits per year, subject to the deductible  Covered at 60% for up to 210 visits per year, subject to the deductible  Covered at 60% subject to \$500 copay per admission for up to 210 days per year, subject to the deductible  Covered at 60% for up to 210 visits per year, subject to the deductible  Covered at 60% subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year  Durable medical equipment  External prosthetics  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 for a single purchase once every 3 years  Vision Benefits  In-Network  Adult Routine Vision Exam  One routine exam covered in full per year, subject to the deductible  Covered at 60%, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam ev	Other Services	In-Network	Out-of-Network
Hospice Subject to \$500 copay per admission for up to 210 days per year, subject to the deductible Covered at 60% for up to 210 visits per year, subject to the deductible Outpatient therapy \$25 per visit, subject to deductible for physical, speech and occupational therapy for up to 60 Visits per contract year 60 visits per contract year Covered at 50%, subject to the deductible equipment Covered at 50%, subject to the deductible Tovered Covered at 50%, subject to the deductible Vision Benefits In-Network Out-of-Network Covered at 50% for one routine exam every year, subject to the deductible Covered at 50%, subject to the deductible Covered at 50%, subject to the deductible Covered at 50% for one routine exam every year, subject to the deductible Covered at 50% for one routine exam every year, subject to the deductible Covered at 50%, subject to the deductible Covered at 50%, subject to the deductible Covered at 50% for one routine exam every year, subject to the deductible Covered at 50%, subject to the deductible Covered at 50%, subject to the deductible Covered at 50% for one routine exam every year, subject to the deductible Covered at 50%, subject to the deductible for one purchase	Skilled nursing facility	Subject to \$500 copay per admission for up to 200 days per year, subject to the deductible	Covered at 60% per admission for up to 200 days per year, subject to the deductible
Outpatient therapy  \$25 per visit, subject to deductible for physical, speech and occupational therapy for up to 60  Urable medical equipment  External prosthetics  Covered at 50%, subject to the deductible  Covered at 60%, subject to the deductible for a single purchase once every 3 years  Vision Benefits  In-Network  Adult Routine Vision Exam  Adult Diagnostic Vision  \$40 copay per visit, subject to deductible  Covered at 60%, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Adult Eyewear  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  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  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 ye	Home care	\$25 copay per visit for 40 visits per year, subject to the deductible	Covered at 60%. for up to 40 visits per year, subject to the deductible
visits per contract year  Durable medical equipment  External prosthetics  Covered at 50%, subject to the deductible  External prosthetics  Covered at 50%, subject to the deductible  Covered at 60%, subject to the deductible  Acupuncture  \$40 copay per visit, subject to deductible for a single purchase once every 3 years  Vision Benefits  In-Network  Adult Routine Vision Exam  Adult Diagnostic Vision  Exemal prosthetics  Covered at 50%, subject to the deductible for a single purchase once every 3 years  Covered at 60%, subject to the deductible for a single purchase once every 3 years  Vision Benefits  In-Network  Adult Diagnostic Vision  \$40 copay per visit, subject to deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60%, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60%, subject to the deductible for one purchase per plan year  Covered at 60%, subject to the deductible for one purchase per plan year  Covered at 60%, subject to the deductible for one purchase per plan year  Covered at 60%, subject to the deductible for one purchase per plan year  Covered at 60%, subject to the deductible for one purchase per plan year  Covered at 60%, subject to the deductible for one purchase per plan year  Covered at 60%, subject to the deductible	Hospice	Subject to \$500 copay per admission for up to 210 days per year, subject to the deductible	Covered at 60% for up to 210 visits per year, subject to the deductible
equipment  External prosthetics Covered at 50%, subject to the deductible Covered at 50%, subject to the deductible Covered at 60%, subject to the deductible Covered at 50%, subject to the deductible Covered at 50%, subject to the deductible for a single purchase once every 3 years  Vision Benefits In-Network Out-of-Network Adult Routline 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 Covered at 60% for one routine exam every year, subject to the deductible Covered at 60% for one routine exam every year, subject to the deductible Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible  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 Covered at 60% for one routine exam every year, subject to the deductible Covered at 60% for one routine exam every year, subject to the deductible Covered at 50%, subject to the deductible for one purchase per plan year  Pediatric Eyewear Covered at 50%, subject to the deductible for one purchase per plan year  Dental Benefits In-Network Adult Dental Care Not Covered Not Covered Not Covered	Outpatient therapy		Covered at 60%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year
Chiropractic \$25 copay per visit, subject to deductible Covered at 60%, subject to the deductible  Acupuncture \$40 copay per visit, subject to 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  Vision Benefits In-Network  Adult Routine Vision Exam One routine exam covered in full per year, subject to the deductible  Adult Diagnostic Vision \$40 copay per visit, subject to deductible  Adult Eyewear Eyewear Reimbursement of \$100 per year  Pediatric Routine Vision 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  Eyewear Reimbursement of \$100 per year  Pediatric Routine Vision 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  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible for one purchase per plan year  Covered at 60% for one routine exam every year, subject to the deductible for one purchase per plan year  Not Covered  Not Covered		Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
Acupuncture \$40 copay per visit, subject to deductible Covered at 50%, subject to the deductible Covered at 50%, subject to the deductible for a single purchase once every 3 years  Vision Benefits In-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 Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible Eyewear Reimbursement of \$100 per year  Pediatric Routine Vision One routine exam covered in full per year, subject to the deductible Eyewear Reimbursement of \$100 per year  Pediatric Routine Vision 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 Covered at 60% for one routine exam every year, subject to the deductible Covered at 60% for one routine exam every year, subject to the deductible Covered at 60% for one routine exam every year, subject to the deductible Covered at 50%, subject to the deductible for one purchase per plan year  Pediatric Eyewear Covered at 50%, subject to the deductible for one purchase per plan year  Pental Benefits In-Network  Adult Dental Care Not Covered  Not Covered  Not Covered  Not Covered	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  Adult Routine Vision Exam  One routine exam covered in full per year, subject to the deductible  Adult Diagnostic Vision  Adult Eyewear  Eyewear Reimbursement of \$100 per year  Eyewear Reimbursement of \$100 per year  Pediatric Routine Vision  Exam  Covered at 50%, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  Covered at 60% for one routine exam every year, subject to the deductible  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  Adult Dental Care  Not Covered  Not Covered  Not Covered	Chiropractic	\$25 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Vision BenefitsIn-NetworkOut-of-NetworkAdult Routine Vision ExamOne routine exam covered in full per year, subject to the deductibleCovered at 60% for one routine exam every year, subject to the deductibleAdult Diagnostic Vision\$40 copay per visit, subject to deductibleCovered at 60%, 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 60% 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	Acupuncture	\$40 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
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 Covered at 60%, subject to the deductible Eyewear Reimbursement of \$100 per year Eyewear Reimbursement of \$100 per year Covered at 60% for one routine exam every year, subject to the deductible Covered at 60% for one routine exam every year, subject to the deductible Covered at 60% for one routine exam every year, subject to the deductible Exam 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 Out-of-Network  Adult Dental Care Not Covered  Not Covered  Not Covered  Not Covered  Not 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 \$40 copay per visit, subject to deductible Covered at 60%, subject to the deductible  Eyewear Reimbursement of \$100 per year  Pediatric Routine Vision Exam  Pediatric Eyewear Covered at 50%, 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  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  Out-of-Network  Adult Dental Care Not Covered  Not Covered  Not Covered  Not Covered	Vision Benefits	In-Network	Out-of-Network
Adult Eyewear Reimbursement of \$100 per year  Pediatric Routine Vision Exam  Pediatric Eyewear Reimbursement of \$100 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  Covered at 50%, subject to the deductible for one purchase per plan year  Out-of-Network  Adult Dental Care  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered	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
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  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  Adult Dental Care  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered	Adult Diagnostic Vision	\$40 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Exam  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  Out-of-Network  Adult Dental Care  Not Covered  Not Covered  Not Covered  Not Covered	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 60% for one routine exam every year, subject to the deductible
Adult Dental Care Not Covered Not Covered  Pediatric Dental: Not Covered 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
		Not Covered	Not Covered

	SimplyBlue Plus Gold 21	
Pediatric Major Dental Care & Medical Ortho	Not Covered	Not Covered
	\$150 copay per visit 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.

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