



Version Updated: 10/28/2021

Rating Region: Syracuse

| | SimplyBlue Plus Standard Gold | SimplyBlue Plus Standard Gold | | |
|------------------------------|--|--|------------|----------------|
| Plan Overview | | | | |
| Plan ID | 78124NY0990041-00 | 78124NY0990041-00 (SYD9) | | |
| Plan Name | SimplyBlue Plus Standard Gold | SimplyBlue Plus Standard Gold | | |
| 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 | 04/01/2021 - 06/30/2021 | 04/01/2022 - 06/30/2022 | | |
| Rate (\$) | Small Group | Small Group | | |
| Single | \$788.15 | \$844.56 | | |
| Subscriber & Spouse | \$1,576.30 | \$1,689.12 | | |
| Subscriber & Child(ren) | \$1,339.86 | \$1,435.75 | | |
| Family | \$2,246.23 | \$2,407.00 | | |
| Plan features | | | | |
| Primary Care Physician (PCP) | Not Required | Not Required | | |
| Referrals | Not Required | Not Required | | |
| Out of network benefits | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible | | |
| Out of area benefits | Coverage provided worldwide through our BlueCardÂ® 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 | ExerciseRewardsÂ® receive up to \$600 in rewards a year by visiting a qualified fitness facility and save on Gym memberships with Active&Fit DirectÂ®. | 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 | \$25 copay per visit, subject to deductible | Covered at 60%, subject to the deductible | \$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 | \$40 copay per visit, subject to deductible | Covered at 60%, subject to the deductible |
| Coinsurance | Covered at 100% | Covered at 60% | Covered at 100% | Covered at 60% |
| Deductible | In-Network: \$600 Individual / \$1,200 Family | Out-of-Network: \$5,000 Individual / \$10,000 Family | In-Network: \$600 Individual / \$1,200 Family | Out-of-Network: \$5,000 Individual / \$10,000 Family |
| Out of pocket maximum | In-Network: \$4,000 Individual / \$8,000 Family | Out-of-Network: \$10,000 Individual / \$20,000 Family | \$4,000 Individual / \$8,000 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 60%, subject to the deductible | Covered In Full | Covered at 60%, subject to the deductible |
| Adult routine physical exams | Covered In Full | Covered at 60%, subject to the deductible | Covered In Full | Covered at 60%, subject to the deductible |
| +Adult immunizations | Covered In Full | Covered at 60%, subject to the deductible | Covered In Full | Covered at 60%, subject to the deductible |
| +Mammography | Covered In Full | Covered at 60%, subject to the deductible | Covered In Full | Covered at 60%, subject to the deductible |
| +Pap smear | Covered In Full | Covered at 60%, subject to the deductible | Covered In Full | Covered at 60%, subject to the deductible |
| Routine GYN Exam | Covered In Full | Covered at 60%, subject to the deductible | Covered In Full | Covered at 60%, subject to the deductible |
| +Prostate cancer screening | Covered In Full | Covered at 60%, subject to the deductible | Covered In Full | Covered at 60%, subject to the deductible |
| +Colonoscopy | Preventive screenings covered in full | Covered at 60%, subject to the deductible | 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 | Covered In Full | Covered at 60%, subject to the deductible |
| Physician Office Services | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Diagnostic office visits | \$25 PCP copay; \$40 Specialist copay per visit, subject to deductible | Covered at 60%, subject to the deductible | \$25 PCP copay; \$40 Specialist copay per visit, subject to deductible | Covered at 60%, subject to the deductible |
| Telemedicine and Telehealth Services | Covered in Full | Covered at 60%, subject to the deductible | Covered In Full | Covered at 60%, subject to the deductible |
| Diagnostic x-rays | \$25 PCP copay; \$40 copay per visit, subject to deductible | Covered at 60%, subject to the deductible | \$25 PCP copay; \$40 copay per visit, subject to deductible | Covered at 60%, subject to the deductible |
| Advanced Imaging Services | \$40 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible | \$40 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible |
| Diagnostic laboratory and pathology | \$25 PCP copay; \$40 Specialist copay per visit, subject to deductible | Covered at 60%, subject to the deductible | \$25 PCP copay; \$40 Specialist 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 | \$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 | \$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 | \$25 PCP copay per visit, subject to deductible | Covered at 60%, subject to the deductible |
| Radiation therapy | \$25 PCP copay per visit, subject to deductible | Covered at 60%, subject to the deductible | \$25 PCP copay per visit, subject to deductible | Covered at 60%, 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 | Covered at 60%, subject to the deductible | Covered in full (Cost share may apply to | Covered at 60%, subject to the deductible |

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| | ultrasounds, lab work and sick visits) | | ultrasounds, lab work and sick visits) | |
| Hospital care for mom (including delivery) | Subject to \$1,000 copay per admission, subject to the deductible | Covered at 60% per admission, subject to the deductible | Subject to \$1,000 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 | Covered In Full, subject to deductible | Covered at 60% per admission, subject to the deductible |
| Prescription Drug | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Prescription Drug Coverage | \$10/\$35/\$70 | Not Covered | \$10/\$35/\$70 | Not Covered |
| Diabetic drugs, insulin, and supplies | \$25 copay, subject to deductible per 30 day supply | Covered at 60%, subject to the deductible | \$25 copay, subject to deductible per 30 day supply | Covered at 60%, subject to the deductible |
| Inpatient Hospital Benefits | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Hospital benefits | Subject to \$1,000 copay per admission for unlimited days, subject to the deductible | Covered at 60% per admission for unlimited days, subject to the deductible | Subject to \$1,000 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 | Covered at 60%, subject to the deductible | Covered In Full | Covered at 60%, subject to the deductible |
| Inpatient physical rehabilitation | Subject to \$1,000 copay per admission for up to 60 days per contract year, subject to the deductible | Covered at 60% per admission for up to 60 days per contract year, subject to the deductible | Subject to \$1,000 copay per admission for up to 60 days 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 | \$100 copay per visit, subject to deductible | Covered at 60%, subject to the deductible | \$100 copay per visit, subject to deductible | Covered at 60%, subject to the deductible |
| Anesthesia | Covered In Full | Covered at 60%, subject to the deductible | Covered In Full | Covered at 60%, subject to the deductible |
| Emergency Care | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Emergency room care | \$150 copay per visit, subject to deductible | \$150 copay per visit, subject to deductible | \$150 copay per visit, subject to deductible | \$150 copay per visit, subject to deductible |
| Freestanding urgent care center | \$60 copay per visit, subject to deductible | Covered at 60%, subject to the deductible | \$60 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 | \$150 copay per visit, subject to deductible | \$150 copay per visit, subject to deductible |
| Outpatient Hospital Benefits | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Diagnostic x-rays | \$40 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible | \$40 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible |
| Advanced Imaging Services | \$40 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible | \$40 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible |
| Diagnostic laboratory and pathology | \$40 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible | \$40 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible |
| Surgical Care Facility Fee | \$100 copay per visit; subject to deductible | Covered at 60%, subject to the deductible | \$100 copay per visit; subject to deductible | Covered at 60%, subject to the deductible |
| Chemotherapy | \$25 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible | \$25 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible |
| Radiation Therapy | \$25 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible | \$25 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible |
| Mental Health and Substance Use | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Inpatient mental health care | Subject to \$1,000 copay per admission for unlimited days, subject to the deductible | Covered at 60% per admission for unlimited days, subject to the deductible | Subject to \$1,000 copay 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 | \$25 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible | \$25 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible |
| Inpatient substance use | Subject to \$1,000 copay per admission for | Covered at 60% per admission for unlimited | Subject to \$1,000 copay per admission for | Covered at 60% per admission for unlimited |

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| | unlimited days, subject to the deductible | days, subject to the deductible | unlimited days, subject to the deductible | days, subject to the deductible |
| Outpatient substance use | \$25 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible | \$25 copay per visit, subject to the deductible | Covered at 60%, subject to the deductible |
| Other Services | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Skilled nursing facility | Subject to \$1,000 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 | Subject to \$1,000 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 |
| 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 | \$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 |
| Hospice | Subject to \$1,000 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 | Subject to \$1,000 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 | \$30 per visit, subject to 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 | \$30 per visit, subject to 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 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible |
| External prosthetics | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible |
| Chiropractic | \$40 Specialist copay per visit, subject to deductible | Covered at 60%, subject to the deductible | \$40 Specialist copay per visit, subject to deductible | Covered at 60%, subject to the deductible |
| Acupuncture | Not Covered | Not Covered | Not Covered | Not Covered |
| Hearing Aids | Covered at 80% , 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 80% , 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 | Out-of-Network | In-Network | Out-of-Network |
| Adult Routine Vision Exam | Not Covered | Not Covered | Not Covered | Not Covered |
| Adult Diagnostic Vision | \$25 PCP copay; \$40 Specialist copay per visit, subject to deductible | Covered at 60%, subject to the deductible | \$25 PCP copay; \$40 Specialist copay per visit, subject to deductible | Covered at 60%, subject to the deductible |
| Adult Eyewear | Not Covered | Not Covered | Not Covered | Not Covered |
| Pediatric Routine Vision Exam | \$25 copay per visit for one routine exam every year, subject to the deductible | Covered at 60% for one routine exam every year, subject to the deductible | \$25 copay per visit for one routine exam every year, subject to the deductible | Covered at 60% for one routine exam every year, subject to the deductible |
| Pediatric Eyewear | Covered at 80%, 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 80%, subject to the deductible for one purchase per plan year | Covered at 60%, 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 | \$25 per visit, subject to the deductible | \$25 per visit, subject to the deductible and balance billing | \$25 per visit, subject to the deductible | \$25 per visit, subject to the deductible and balance billing |
| Pediatric Major Dental Care & Medical Ortho | \$25 per visit, subject to the deductible | \$25 per visit, subject to the deductible and balance billing | \$25 per visit, subject to the deductible | \$25 per visit, subject to the deductible and balance billing |
| Accidental Dental - Outpatient Surgical | \$100 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 | \$100 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.

