Version Updated: 10/28/2021

Rating Region: Rochester

	SimplyBlue Plus Standard Platinum		SimplyBlue Plus Standard Platinum	
Plan Overview				
Plan ID	78124NY0980009-00		78124NY0980009-00 (SXM3)	
Plan Name	SimplyBlue Plus Standard Platinum		SimplyBlue Plus Standard Platinum	
Aggregation Design	Individual Aggregation		Individual Aggregation	
Plan Highlights	Predictable out-of-pocket costs without a deductible, includes ExerciseRewards.		Predictable out-of-pocket costs without a deductible, includes Active&Fit ExerciseRewards.	
Plan Type	Copay		Copay	
HSA Eligible	No		No	
Quote Effective	10/01/2021 - 12/31/2021		10/01/2022 - 12/31/2022	
Rate ($)	**Small Group**		**Small Group**	
Single	$797.02		$865.74	
Subscriber & Spouse	$1,594.04		$1,731.48	
Subscriber & Child(ren)	$1,354.93		$1,471.76	
Family	$2,271.51		$2,467.36	
Plan features				
Primary Care Physician (PCP)	Not Required		Not Required	
Referrals	Not Required		Not Required	
Out of network benefits	Covered at 80%, subject to the deductible		Covered at 80%, 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	$15 copay per visit	Covered at 80%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible
Specialist Office Visit	$35 copay per visit	Covered at 80%, subject to the deductible	$35 copay per visit	Covered at 80%, subject to the deductible
Coinsurance	None	Covered at 80%	None	Covered at 80%
Deductible	None	Out-of-Network: $5,000 Individual / $10,000 Family	None	Out-of-Network: $5,000 Individual / $10,000 Family
Out of pocket maximum	In-Network: $2,000 Individual / $4,000 Family	Out-of-Network: $10,000 Individual / $20,000 Family	$2,000 Individual / $4,000 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 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
Adult routine physical exams	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
+Adult immunizations	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
+Mammography	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
+Pap smear	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
Routine GYN Exam	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
+Prostate cancer screening	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
+Colonoscopy	Preventive screenings covered in full	Covered at 80%, subject to the deductible	Preventive screenings covered in full	Covered at 80%, subject to the deductible
+Family Planning Services	Covered in full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
Physician Office Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic office visits	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible
Telemedicine and Telehealth Services	Covered in Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
Diagnostic x-rays	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible
Advanced Imaging Services	$35 copay per visit	Covered at 80%, subject to the deductible	$35 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible
Allergy tests	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible
Allergy injections	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible
Chemotherapy	$15 copay	Covered at 80%, subject to the deductible	$15 copay	Covered at 80%, subject to the deductible
Radiation therapy	$15 copay	Covered at 80%, subject to the deductible	$15 copay	Covered at 80%, 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 80%, subject to the deductible	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered at 80%, subject to the deductible
Hospital care for mom (including delivery)	Subject to $500 copay per admission	Covered at 80%, per admission, subject to the deductible	Subject to $500 copay per admission	Covered at 80%, per admission, subject to the deductible

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Newborn nursery care	Covered In Full	Covered at 80%, per admission, subject to the deductible	Covered In Full	Covered at 80%, per admission, subject to the deductible
Prescription Drug	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Coverage	$10/$30/$60	Not Covered	$10/$30/$60	Not Covered
Diabetic drugs, insulin, and supplies	$15 copay per 30 day supply	Covered at 80%, subject to the deductible	$15 copay per 30 day supply	Covered at 80%, subject to the deductible
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital benefits	Subject to $500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to $500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible
Physician visits in the hospital	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
Inpatient physical rehabilitation	Subject to $500 copay per admission for up to 60 days per contract year	Covered at 80%, per admission for up to 60 days per contract year, subject to the deductible	Subject to $500 copay per admission for up to 60 days per contract year	Covered at 80%, per admission for up to 60 days per contract year, subject to the deductible
Surgery	$100 copay per visit	Covered at 80%, subject to the deductible	$100 copay per visit	Covered at 80%, subject to the deductible
Anesthesia	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
Emergency Care	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency room care	$100 copay per visit	$100 copay per visit	$100 copay per visit	$100 copay per visit
Freestanding urgent care center	$55 copay per visit	Covered at 80%, subject to the deductible	$55 copay per visit	Covered at 80%, subject to the deductible
Ambulance	$100 copay per visit	$100 copay per visit	$100 copay per visit	$100 copay per visit
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic x-rays	$35 copay per visit	Covered at 80%, subject to the deductible	$35 copay per visit	Covered at 80%, subject to the deductible
Advanced Imaging Services	$35 copay per visit	Covered at 80%, subject to the deductible	$35 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	$35 copay per visit	Covered at 80%, subject to the deductible	$35 copay per visit	Covered at 80%, subject to the deductible
Surgical Care Facility Fee	$100 copay per visit	Covered at 80%, subject to the deductible	$100 copay per visit	Covered at 80%, subject to the deductible
Chemotherapy	$15 copay per visit	Covered at 80%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible
Radiation Therapy	$15 copay per visit	Covered at 80%, subject to the deductible	$15 copay per visit	Covered at 80%, 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 $500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to $500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible
Outpatient mental health care	$15 copay per visit	Covered at 80%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible
Inpatient substance use	Subject to $500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible	Subject to $500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible
Outpatient substance use	$15 copay per visit	Covered at 80%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible
Other Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**

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Skilled nursing facility	Subject to $500 copay per admission for up to 200 days per year	Covered at 80%, per admission for up to 200 days per year, subject to the deductible	Subject to $500 copay per admission for up to 200 days per year	Covered at 80%, per admission for up to 200 days per year, subject to the deductible
Home care	$15 copay per visit for 40 visits per year	Covered at 80%, for up to 40 visits per year, subject to the deductible	$15 copay per visit for 40 visits per year	Covered at 80%, for up to 40 visits per year, subject to the deductible
Hospice	Subject to $500 copay per admission for up to 210 days per year	Covered at 80%, for up to 210 days per year, subject to the deductible	Subject to $500 copay per admission for up to 210 days per year	Covered at 80%, for up to 210 days per year, subject to the deductible
Outpatient therapy	$25 per visit for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 80%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	$25 per visit for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 80%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year
Durable medical equipment	Covered at 90%	Covered at 80%, subject to the deductible	Covered at 90%	Covered at 80%, subject to the deductible
External prosthetics	Covered at 90%	Covered at 80%, subject to the deductible	Covered at 90%	Covered at 80%, subject to the deductible
Chiropractic	$35 copay	Covered at 80%, subject to the deductible	$35 copay	Covered at 80%, subject to the deductible
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Aids	Covered at 90% 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 90% for a single purchase once every 3 years	Covered at 80%, 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	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible
Adult Eyewear	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Routine Vision Exam	$15 copay per visit for one routine exam every year	Covered at 80% for one routine exam every year, subject to the deductible	$15 copay per visit for one routine exam every year	Covered at 80% for one routine exam every year, subject to the deductible
Pediatric Eyewear	Covered at 90%, for one purchase per plan year	Covered at 80%, subject to the deductible for one purchase per plan year	Covered at 90%, for one purchase per plan year	Covered at 80%, 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	$15 per visit	$15 per visit, subject to the deductible and balance billing	$15 per visit	$15 per visit, subject to the deductible and balance billing
Pediatric Major Dental Care & Medical Ortho	$15 per visit	$15 per visit, subject to the deductible and balance billing	$15 per visit	$15 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	Covered at 80% 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	Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible