Version Updated: 10/28/2021

Rating Region: Utica

	SimplyBlue Plus Standard Silver		SimplyBlue Plus Standard Platinum	
Plan Overview				
Plan ID	78124NY0990009-00		78124NY0980009-00 (SXM3)	
Plan Name	SimplyBlue Plus Standard Silver		SimplyBlue Plus Standard Platinum	
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.		Predictable out-of-pocket costs without a deductible, includes Active&Fit ExerciseRewards.	
Plan Type	Hybrid		Copay	
HSA Eligible	No		No	
Quote Effective	04/01/2021 - 06/30/2021		04/01/2022 - 06/30/2022	
Rate ($)	**Small Group**		**Small Group**	
Single	$713.22		$1,024.52	
Subscriber & Spouse	$1,426.44		$2,049.04	
Subscriber & Child(ren)	$1,212.47		$1,741.68	
Family	$2,032.68		$2,919.88	
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 80%, 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	ExerciseRewardsÃ‚Â® receive up to $600 in rewards a year by visiting a qualified fitness facility and save on Gym memberships with Active&Fit DirectÃ¢â€žÂ¢.		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**

	SimplyBlue Plus Standard Silver		SimplyBlue Plus Standard Platinum	
Primary Care Office Visit	$30 copay per visit, subject to deductible	Covered at 60%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible
Specialist Office Visit	$50 copay per visit, subject to deductible	Covered at 60%, subject to the deductible	$35 copay per visit	Covered at 80%, subject to the deductible
Coinsurance	Covered at 100%	Covered at 60%	None	Covered at 80%
Deductible	In-Network: $1,300 Individual / $2,600 Family	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: $8,500 Individual / $17,000 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 60%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
Adult routine physical exams	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
+Adult immunizations	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
+Mammography	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
+Pap smear	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
Routine GYN Exam	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
+Prostate cancer screening	Covered In Full	Covered at 60%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
+Colonoscopy	Preventive screenings covered in full	Covered at 60%, subject to the deductible	Preventive screenings covered in full	Covered at 80%, subject to the deductible
+Family Planning Services	Covered in full	Covered at 60%, 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	$30 PCP copay; $50 Specialist copay per visit, subject to deductible	Covered at 60%, 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 60%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
Diagnostic x-rays	$30 PCP copay; $75 copay per visit, subject to deductible	Covered at 60%, subject to the deductible	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible
Advanced Imaging Services	$75 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible	$35 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	$30 PCP copay; $50 Specialist copay per visit, subject to deductible	Covered at 60%, subject to the deductible	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible
Allergy tests	$30 PCP copay; $50 Specialist copay per visit, subject to deductible	Covered at 60%, subject to the deductible	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible
Allergy injections	$30 PCP copay; $50 Specialist copay per visit, subject to deductible	Covered at 60%, subject to the deductible	$15 PCP copay; $35 Specialist copay per visit	Covered at 80%, subject to the deductible
Chemotherapy	$30 PCP copay per visit, subject to deductible	Covered at 60%, subject to the deductible	$15 copay	Covered at 80%, subject to the deductible
Radiation therapy	$30 PCP copay per visit, subject to deductible	Covered at 60%, 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	Covered at 60%, subject to the deductible	Covered in full (Cost share may apply to	Covered at 80%, subject to the deductible

	SimplyBlue Plus Standard Silver		SimplyBlue Plus Standard Platinum	
	ultrasounds, lab work and sick visits)		ultrasounds, lab work and sick visits)	
Hospital care for mom (including delivery)	Subject to $1,500 copay per admission, subject to the deductible	Covered at 60% per admission, subject to the deductible	Subject to $500 copay per admission	Covered at 80%, 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	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/$35/$70	Not Covered	$10/$30/$60	Not Covered
Diabetic drugs, insulin, and supplies	$30 copay, subject to deductible per 30 day supply	Covered at 60%, 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 $1,500 copay per admission for unlimited days, subject to the deductible	Covered at 60% 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 60%, subject to the deductible	Covered In Full	Covered at 80%, subject to the deductible
Inpatient physical rehabilitation	Subject to $1,500 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 $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	$150 copay per visit, subject to deductible	Covered at 60%, subject to the deductible	$100 copay per visit	Covered at 80%, subject to the deductible
Anesthesia	Covered In Full	Covered at 60%, 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	$300 copay per visit, subject to deductible	$300 copay per visit, subject to deductible	$100 copay per visit	$100 copay per visit
Freestanding urgent care center	$70 copay per visit, subject to deductible	Covered at 60%, subject to the deductible	$55 copay per visit	Covered at 80%, subject to the deductible
Ambulance	$150 copay per visit, subject to deductible	$150 copay per visit, subject to deductible	$100 copay per visit	$100 copay per visit
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic x-rays	$75 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible	$35 copay per visit	Covered at 80%, subject to the deductible
Advanced Imaging Services	$75 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible	$35 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	$50 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible	$35 copay per visit	Covered at 80%, subject to the deductible
Surgical Care Facility Fee	$150 copay per visit; subject to deductible	Covered at 60%, subject to the deductible	$100 copay per visit	Covered at 80%, subject to the deductible
Chemotherapy	$30 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible
Radiation Therapy	$30 copay per visit, subject to the deductible	Covered at 60%, 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 $1,500 copay per admission for unlimited days, subject to the deductible	Covered at 60% 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	$30 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible	$15 copay per visit	Covered at 80%, subject to the deductible
Inpatient substance use	Subject to $1,500 copay per admission for	Covered at 60% per admission for unlimited	Subject to $500 copay per admission for	Covered at 80%, per admission for unlimited

	SimplyBlue Plus Standard Silver		SimplyBlue Plus Standard Platinum	
	unlimited days, subject to the deductible	days, subject to the deductible	unlimited days	days, subject to the deductible
Outpatient substance use	$30 copay per visit, subject to the deductible	Covered at 60%, 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**
Skilled nursing facility	Subject to $1,500 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	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	$30 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	$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 $1,500 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	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	$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	$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 70%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 90%	Covered at 80%, subject to the deductible
External prosthetics	Covered at 70%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 90%	Covered at 80%, subject to the deductible
Chiropractic	$50 Specialist copay per visit, subject to deductible	Covered at 60%, 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 70% , 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 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	$30 PCP copay; $50 Specialist copay per visit, subject to deductible	Covered at 60%, 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	$30 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	$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 70%, 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 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	$30 per visit, subject to the deductible	$30 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	$30 per visit, subject to the deductible	$30 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	$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	$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

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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