	SimplyBlue Plus Gold 5	
Plan Overview		
Plan ID	78124NY0980138-01 (GVG2)	
Plan Name	SimplyBlue Plus Gold 5	
Aggregation Design	Individual Aggregation	
Plan Highlights	Predictable out-of-pocket costs without a deductible, includes ThriveWell.	
Plan Type	Copay	
HSA Eligible	No	
Quote Effective	01/01/2025 - 03/31/2025	
Plan features		
Primary Care Physician (PCP)	Not Required	
Referrals	Not Required	
Out of network benefits	Covered at 80%, 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	ThriveWell, a digital home base dedicated to engaging in health and wellbeing. This digital hub will include rewards of up to $200 per subscriber and $200 per spouse, or domestic partner, for a total rewards payout of $400 per plan year.	
Plan cost-sharing highlights		
Plan cost-sharing highlights	**In-Network**	**Out-of-Network**
Primary Care Office Visit	$40 copay per visit	Covered at 80%, subject to the deductible
Specialist Office Visit	$70 copay per visit	Covered at 80%, subject to the deductible
Coinsurance	None	Covered at 80%
Deductible	None	Out-of-Network: $5,000 Individual / $10,000 Family
Out of pocket maximum	In-Network: $9,200 Individual / $18,400 Family	Out-of-Network: $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 80%, subject to the deductible
Adult routine physical exams	Covered In Full	Covered at 80%, subject to the deductible
+Adult immunizations	Covered In Full	Covered at 80%, subject to the deductible
+Mammography	Covered In Full	Covered at 80%, subject to the deductible
+Pap smear	Covered In Full	Covered at 80%, subject to the deductible
Routine GYN Exam	Covered In Full	Covered at 80%, subject to the deductible
+Prostate cancer	Covered In Full	Covered at 80%, subject to the deductible

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screening		
+Colonoscopy	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
Physician Office Services	**In-Network**	**Out-of-Network**
Diagnostic Visits	$40 PCP copay; $70 Specialist copay per visit	Covered at 80%, subject to the deductible
Telemedicine	Covered In Full	Covered at 80%, subject to the deductible
Diagnostic x-rays	$70 copay per visit	Covered at 80%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	$70 copay per visit	Covered at 80%, subject to the deductible
Allergy tests	$40 PCP copay; $70 Specialist copay per visit	Covered at 80%, subject to the deductible
Allergy injections	$40 PCP copay; $70 Specialist copay per visit	Covered at 80%, subject to the deductible
Chemotherapy	$40 copay per visit	Covered at 80%, subject to the deductible
Radiation therapy	$70 copay per visit	Covered at 80%, 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 80%, subject to the deductible per admission
Hospital care for mom (including delivery)	Subject to $1,500 copay per admission	Covered at 80%, per admission, subject to the deductible
Newborn nursery care	Covered In Full	Covered at 80%, per admission, subject to the deductible
Prescription Drug	**In-Network**	**Out-of-Network**
Prescription Drug Coverage	$15/$100/50% $0 generics for kids up to age 19	Not Covered
Diabetic drugs, insulin, and supplies	$40 copay per 30 day supply Insulin: Covered in full	Covered at 80%, subject to the deductible
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Hospital benefits	Subject to $1,500 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 per admission
Inpatient physical rehabilitation	Subject to $1,500 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	Covered In Full	Covered at 80%, subject to the deductible per admission
Anesthesia	Covered In Full	Covered at 80%, subject to the deductible
Emergency Care	**In-Network**	**Out-of-Network**
Emergency room care	$650 copay per visit	$650 copay per visit
Freestanding urgent care center	$70 copay per visit	Covered at 80%, subject to the deductible
Ambulance	$650 copay	$650 copay
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**

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Diagnostic x-rays	$70 copay per visit	Covered at 80%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	$70 copay per visit	Covered at 80%, subject to the deductible
Surgical Care Facility Fee	$650 copay per visit	Covered at 80%, subject to the deductible
Chemotherapy	$40 copay per visit	Covered at 80%, subject to the deductible
Radiation Therapy	$70 copay per visit	Covered at 80%, subject to the deductible
Mental Health and Substance Use	**In-Network**	**Out-of-Network**
Inpatient mental health care	Subject to $1,500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible
Outpatient mental health care	Covered in Full	Covered at 80%, subject to the deductible
Inpatient substance use	Subject to $1,500 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible
Outpatient substance use	Covered in Full	Covered at 80%, subject to the deductible
Other Services	**In-Network**	**Out-of-Network**
Skilled nursing facility	Subject to $1,500 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	$40 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	Covered at 80%, for up to 210 days per year, subject to the deductible
Outpatient therapy	$40 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 50%	Covered at 50%, subject to the deductible
External prosthetics	Covered at 50%	Covered at 50%, subject to the deductible
Chiropractic	$40 copay per visit	Covered at 80%, subject to the deductible
Acupuncture	$40 copay per visit 10 visits per benefit period	Covered at 80%, subject to the deductible
Hearing Aids	Covered at 50% 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	Covered at 80% for one routine exam every year, subject to the deductible
Adult Diagnostic Vision	$70 copay per visit	Covered at 80%, subject to the deductible
Adult Eyewear	Eyewear Reimbursement of $100 per year	Eyewear Reimbursement of $100 per year
Pediatric Routine Vision Exam	One routine exam covered in full per year	Covered at 80% for one routine exam every year, subject to the deductible
Pediatric Eyewear	Covered at 50% 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: Preventive & Routine	Not Covered	Not Covered
Pediatric Major Dental	Not Covered	Not Covered

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Care & Medical Ortho		
Accidental Dental - Outpatient Surgical	$650 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