

SimplyBlue Plus Gold 5		
Plan Overview		
Plan ID	78124NY0980138-00	
Plan Name	SimplyBlue Plus Gold 5	
Aggregation Design	Individual Aggregation	
Plan Highlights	Predictable out-of-pocket costs without a deductible, includes ThriveWell SM .	
Plan Type	Copay	
HSA Eligible	No	
Quote Effective	01/01/2027 - 03/31/2027	
Plan Feature		
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 SM , a digital home base dedicated to engaging in health and wellbeing. This digital hub includes 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 deductible
Specialist Office Visit	\$70 copay per visit	Covered at 80%, subject to 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

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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 deductible
Adult Routine physical exams	Covered in Full	Covered at 80%, subject to deductible
Adult Immunizations	Covered in Full	Covered at 80%, subject to deductible
Mammography	Covered in Full	Covered at 80%, subject to deductible
Pap Smear	Covered in Full	Covered at 80%, subject to deductible
Routine GYN Exam	Covered in Full	Covered at 80%, subject to deductible
Prostate cancer screening	Covered in Full	Covered at 80%, subject to deductible
Colonoscopy	Covered in Full	Covered at 80%, subject to deductible
Family Planning Services	Covered in Full	Covered at 80%, subject to deductible
Physician Office Services	In Network	Out of Network
Diagnostic Visits	\$40 PCP copay; \$70 Specialist copay per visit	Covered at 80%, subject to deductible
Telemedicine Program	Acute and Behavioral Health, & Digital Physical Therapy Covered in Full Teledermatology \$70 copay per visit	Not Covered
Diagnostic x-rays	\$70 copay per visit	Covered at 80%, subject to deductible
Advanced Imaging Services	\$100 copay per visit	Covered at 80%, subject to deductible
Diagnostic Laboratory and pathology	\$70 copay per visit	Covered at 80%, subject to deductible
Allergy tests	\$40 PCP copay; \$70 Specialist copay per visit	Covered at 80%, subject to deductible
Allergy injections	\$40 PCP copay; \$70 Specialist copay per visit	Covered at 80%, subject to deductible
Chemotherapy	\$40 copay per visit	Covered at 80%, subject to deductible
Radiation therapy	\$70 copay per visit	Covered at 80%, subject to 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 deductible

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Hospital care for mom (including delivery)	Subject to \$1500 copay per admission	Covered at 80% per admission, subject to deductible
Newborn nursery care	Covered in Full	Covered at 80%, subject to deductible
Prescription Drug	In Network	Out of Network
Prescription Drug Coverage	\$15/40%/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 deductible
Inpatient Hospital Benefits	In Network	Out of Network
Hospital benefits	Subject to \$1500 copay per admission for unlimited days	Covered at 80% per admission for unlimited days, subject to deductible
Physician visits in the hospital	Covered in Full	Covered at 80%, subject to deductible
Inpatient physical rehabilitation	Subject to \$1500 copay per admission for up to 60 day(s) per contract year	Covered at 80% per admission for up to 60 day(s) per contract year, subject to deductible
Surgery	Covered in Full	Covered at 80%, subject to deductible
Anesthesia	Covered in Full	Covered at 80%, subject to 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 deductible
Ambulance	\$650 copay per visit	\$650 copay per visit
Outpatient Hospital Benefits	In Network	Out of Network
Diagnostic x-rays	\$70 copay per visit	Covered at 80%, subject to deductible
Advanced Imaging Services	\$100 copay per visit	Covered at 80%, subject to deductible
Diagnostic Laboratory and pathology	\$70 copay per visit	Covered at 80%, subject to deductible
Surgical Care Facility Fee	\$650 copay per visit	Covered at 80%, subject to deductible
Chemotherapy	\$40 copay per visit	Covered at 80%, subject to deductible
Radiation Therapy	\$70 copay per visit	Covered at 80%, subject to deductible
Mental Health and Substance Use	In Network	Out of Network

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Inpatient mental health care	Subject to \$1500 copay per admission for unlimited days	Covered at 80% per admission for unlimited days, subject to deductible
Outpatient mental health care	Covered in Full	Covered at 80%, subject to deductible
Inpatient substance use	Subject to \$1500 copay per admission for unlimited days	Covered at 80% per admission for unlimited days, subject to deductible
Outpatient substance use	Covered in Full	Covered at 80%, subject to deductible
Other Services	In Network	Out of Network
Skilled nursing facility	Subject to \$1500 copay per admission for up to 200 day(s) per year	Covered at 80%, per admission for up to 200 day(s) per year, subject to deductible
Home care	\$40 copay per visit for 40 visits per year	Covered at 80% for 40 visits per year, subject to deductible
Hospice	Subject to \$1500 copay per admission for up to 210 day(s) per year	Covered at 80%, per admission for up to 210 day(s) per year, subject to deductible
Outpatient Therapy	\$40 copay per visit for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 80% for physical, speech and occupational therapy for up to 60 visits per contract year, subject to deductible
Durable medical equipment	Covered at 50%	Covered at 50%, subject to deductible
External prosthetics	Covered at 50%	Covered at 50%, subject to deductible
Chiropractic	\$40 copay per visit	Covered at 80%, subject to deductible
Acupuncture	\$40 copay per visit 10 visit per benefit period	Covered at 80%, subject to deductible 10 visit per benefit period
Hearing Aids	Covered at 50% for a single purchase once every 3 years	Covered at 50%, subject to 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 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

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Pediatric Eyewear	Covered at 50% one purchase per plan year	Covered at 50%, subject to deductible 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 Care & Medical Ortho	Not Covered	Not Covered
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 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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