

SimplyBlue Plus Bronze 3		
Plan Overview		
Plan ID	78124NY1000154-00	
Plan Name	SimplyBlue Plus Bronze 3	
Aggregation Design	Family Aggregation	
Plan Highlights	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ThriveWell SM .	
Plan Type	Deductible HSA	
HSA Eligible	Yes	
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 100%, 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	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Specialist Office Visit	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Coinsurance	Covered at 50%	Covered at 100%
Deductible	In-Network: \$6,500 Individual / \$13,000 Family	Out-of-Network: \$10,000 Individual / \$20,000 Family
Out-of-Pocket Maximum	In-Network: \$8,500 Individual / \$17,000	Out-of-Network: \$10,000 Individual /

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	Family	\$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 100%, subject to deductible
Adult Routine physical exams	Covered in Full	Covered at 100%, subject to deductible
Adult Immunizations	Covered in Full	Covered at 100%, subject to deductible
Mammography	Covered in Full	Covered at 100%, subject to deductible
Pap Smear	Covered in Full	Covered at 100%, subject to deductible
Routine GYN Exam	Covered in Full	Covered at 100%, subject to deductible
Prostate cancer screening	Covered in Full	Covered at 100%, subject to deductible
Colonoscopy	Covered in Full	Covered at 100%, subject to deductible
Family Planning Services	Covered in Full	Covered at 100%, subject to deductible
Physician Office Services	In Network	Out of Network
Diagnostic Visits	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Telemedicine Program	Acute and Behavioral Health, & Digital Physical Therapy Covered in Full Teledermatology Covered at 50%	Not Covered
Diagnostic x-rays	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Advanced Imaging Services	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Diagnostic Laboratory and pathology	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Allergy tests	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Allergy injections	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Chemotherapy	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Radiation therapy	Covered at 50%, subject to deductible	Covered at 100%, 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 100%, subject to deductible
Hospital care for mom (including delivery)	Covered at 50% per admission, subject to	Covered at 100% per admission, subject to

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	deductible	deductible
Newborn nursery care	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Prescription Drug	In Network	Out of Network
Prescription Drug Coverage	\$10/40%/50%, subject to the plan deductible \$0 generics for kids up to age 19, subject to deductible Preventive drugs are not subject to the deductible; they are subject to the copay or coinsurance, if applicable.	Not Covered
Diabetic drugs, insulin, and supplies	Covered at 50%, subject to deductible Insulin: Covered in full	Covered at 100%, subject to deductible
Inpatient Hospital Benefits	In Network	Out of Network
Hospital benefits	Covered at 50% per admission for unlimited days, subject to deductible	Covered at 100% per admission for unlimited days, subject to deductible
Physician visits in the hospital	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Inpatient physical rehabilitation	Covered at 50% per admission for up to 60 day(s) per contract year, subject to deductible	Covered at 100% per admission for up to 60 day(s) per contract year, subject to deductible
Surgery	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Anesthesia	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Emergency Care	In Network	Out of Network
Emergency room care	Covered at 50%, subject to deductible	Covered at 50%, subject to deductible
Freestanding urgent care center	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Ambulance	Covered at 50%, subject to deductible	Covered at 50%, subject to deductible
Outpatient Hospital Benefits	In Network	Out of Network
Diagnostic x-rays	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Advanced Imaging Services	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Diagnostic Laboratory and pathology	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Surgical Care Facility Fee	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible

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Chemotherapy	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Radiation Therapy	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Mental Health and Substance Use	In Network	Out of Network
Inpatient mental health care	Covered at 50% per admission for unlimited days, subject to deductible	Covered at 100% per admission for unlimited days, subject to deductible
Outpatient mental health care	Covered at 100%, subject to the deductible	Covered at 100%, subject to deductible
Inpatient substance use	Covered at 50% per admission for unlimited days, subject to deductible	Covered at 100% per admission for unlimited days, subject to deductible
Outpatient substance use	Covered at 100%, subject to the deductible	Covered at 100%, subject to deductible
Other Services	In Network	Out of Network
Skilled nursing facility	Covered at 50%, per admission for up to 200 day(s) per year, subject to deductible	Covered at 100%, per admission for up to 200 day(s) per year, subject to deductible
Home care	Covered at 50% for 40 visits per year, subject to deductible	Covered at 100% for 40 visits per year, subject to deductible
Hospice	Covered at 50%, per admission for up to 210 day(s) per year, subject to deductible	Covered at 100%, per admission for up to 210 day(s) per year, subject to deductible
Outpatient Therapy	Covered at 50% for physical, speech and occupational therapy for up to 60 visits per contract year, subject to deductible	Covered at 100% for physical, speech and occupational therapy for up to 60 visits per contract year, subject to deductible
Durable medical equipment	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
External prosthetics	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Chiropractic	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible
Acupuncture	Covered at 50%, subject to deductible 10 visit per benefit period	Covered at 100%, subject to deductible 10 visit per benefit period
Hearing Aids	Covered at 50%, subject to deductible for a single purchase once every 3 years	Covered at 100%, 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, subject to the deductible	Covered at 100% for one routine exam every year, subject to the deductible
Adult Diagnostic Vision	Covered at 50%, subject to deductible	Covered at 100%, subject to deductible

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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, subject to the deductible	Covered at 100% for one routine exam every year, subject to the deductible
Pediatric Eyewear	Covered at 50%, subject to deductible one purchase per plan year	Covered at 100%, 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	Covered at 50% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to deductible	Covered at 100% 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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