

SimplyBlue Plus Bronze 7	
<b>Plan Overview</b>	
Plan ID	78124NY1000330-00 (TKI5)
Plan Name	SimplyBlue Plus Bronze 7
Aggregation Design	Individual Aggregation
Plan Highlights	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ThriveWell.
Plan Type	Deductible
HSA Eligible	No
Quote Effective	01/01/2026 - 03/31/2026
<b>Plan features</b>	
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, 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.
<b>Plan cost-sharing highlights</b>	
<b>Plan cost-sharing highlights</b>	<b>Out-of-Network</b>
Primary Care Office Visit	Covered at 100%, subject to the deductible
Specialist Office Visit	Covered at 100%, subject to the deductible
Coinsurance	Covered at 100%
Deductible	Out-of-Network: \$10,600 Individual / \$21,200 Family
Out of pocket maximum	Out-of-Network: \$10,600 Individual / \$21,200 Family
Lifetime maximum	None
<b>Plan Benefits</b>	
<b>Preventive Healthcare Services</b>	<b>Out-of-Network</b>
Well child visits	Covered at 100%, subject to the deductible
Adult routine physical exams	Covered at 100%, subject to the deductible
+Adult immunizations	Covered at 100%, subject to the deductible
+Mammography	Covered at 100%, subject to the deductible
+Pap smear	Covered at 100%, subject to the deductible
Routine GYN Exam	Covered at 100%, subject to the deductible
+Prostate cancer	Covered at 100%, subject to the deductible

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screening		
+Colonoscopy	Preventive screenings covered in full	Covered at 100%, subject to the deductible
+Family Planning Services	Covered In Full	Covered at 100%, subject to the deductible
<b>Physician Office Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Diagnostic Visits	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Telemedicine Program	Acute and Behavioral Health, & Digital Physical Therapy covered in full, subject to the deductible Teledermatology \$0 copay per visit, subject to the deductible	Not Covered
Diagnostic x-rays	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Advanced Imaging Services	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Diagnostic laboratory and pathology	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Allergy tests	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Allergy injections	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Chemotherapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Radiation therapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
<b>Maternity Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Prenatal care	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered at 100%, subject to the deductible
Hospital care for mom (including delivery)	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Newborn nursery care	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
<b>Prescription Drug Coverage</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Prescription Drug Coverage	Covered at 100%, subject to the plan deductible. \$0 generics for kids up to age 19, subject to the plan 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 100%, subject to the deductible Insulin: Covered in full	Covered at 100%, subject to the deductible
<b>Inpatient Hospital Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Hospital benefits	Covered at 100% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible
Physician visits in the hospital	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Inpatient physical rehabilitation	Covered at 100% per 60 day stay per admission per contract year, subject to the deductible	Covered at 100% per 60 day stay per admission per contract year, subject to the deductible
Surgery	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Anesthesia	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
<b>Emergency Care</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Emergency room care	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Freestanding urgent care center	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible

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Ambulance	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
<b>Outpatient Hospital Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Diagnostic x-rays	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Advanced Imaging Services	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Diagnostic laboratory and pathology	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Surgical Care Facility Fee	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Chemotherapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Radiation Therapy	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
<b>Mental Health and Substance Use</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Inpatient mental health care	Covered at 100% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible
Outpatient mental health care	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible
Inpatient substance use	Covered at 100% per admission for unlimited days, subject to the deductible	Covered at 100% per admission for unlimited days, subject to the deductible
Outpatient substance use	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible
<b>Other Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Skilled nursing facility	Covered at 100% per admission for 200 days per year, subject to the deductible	Covered at 100% per admission for 200 days per year, subject to the deductible
Home care	Covered at 100% for up to 40 visits per year, subject to the deductible	Covered at 100% for up to 40 visits per year, subject to the deductible
Hospice	Covered at 100% for up to 210 visits per year, subject to the deductible	Covered at 100% for up to 210 visits per year, subject to the deductible
Outpatient therapy	Covered at 100%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 100%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year
Durable medical equipment	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
External prosthetics	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Chiropractic	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Acupuncture	Not Covered	Not Covered
Hearing Aids	Covered at 100% , subject to the deductible for a single purchase once every 3 years	Covered at 100%, subject to the deductible for a single purchase once every 3 years
<b>Vision Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Adult Routine Vision Exam	Not Covered	Not Covered
Adult Diagnostic Vision	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Adult Eyewear	Not Covered	Not Covered
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 100%, subject to the deductible for one purchase per plan year	Covered at 100%, subject to the deductible for one purchase per plan year
<b>Dental Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental:	Not Covered	Not Covered

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Preventive & Routine	
Pediatric Major Dental Care & Medical Ortho	Not Covered
Accidental Dental - Outpatient Surgical	Covered at 100% 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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