Excellus

Quote Effective: 01/01/2026 - 03/31/2026

Version Updated: 10/01/2025

Rating Region: Syracuse

	SimplyBlue Plus Gold 5	SimplyBlue Plus Gold 17	SimplyBlue Plus Silver 19	SimplyBlue Plus Bronze 4	SimplyBlue Plus Bronze 7
Plan Overview					
Plan ID	78124NY0980137-00 (TIZ2)	78124NY0990249-00 (TJV6)	78124NY1000297-00 (TKF2)	78124NY1000169-00 (TJF6)	78124NY1000329-00 (TKI4)
Plan Name	SimplyBlue Plus Gold 5	SimplyBlue Plus Gold 17	SimplyBlue Plus Silver 19	SimplyBlue Plus Bronze 4	SimplyBlue Plus Bronze 7
Aggregation Design	Individual Aggregation	Individual Aggregation	Family Aggregation	Family Aggregation	Individual Aggregation
Plan Highlights	Predictable out-of-pocket costs without a deductible, includes ThriveWell.	A deductible is applied to select covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full. Plan includes ThriveWell.	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ThriveWell.	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ThriveWell.	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ThriveWell.
Plan Type	Copay	Hybrid	Deductible HSA	Deductible HSA	Deductible
HSA Eligible	No	No	Yes	Yes	No
Quote Effective	01/01/2026 - 03/31/2026	01/01/2026 - 03/31/2026	01/01/2026 - 03/31/2026	01/01/2026 - 03/31/2026	01/01/2026 - 03/31/2026
Rate ($)	**Small Group**	**Small Group**	**Small Group**	**Small Group**	**Small Group**
Single	$1,175.92	$1,136.53	$931.90	$741.83	$662.89
Subscriber & Spouse	$2,351.84	$2,273.06	$1,863.81	$1,483.67	$1,325.78
Subscriber & Child(ren)	$1,999.07	$1,932.11	$1,584.23	$1,261.12	$1,126.92
Family	$3,351.38	$3,239.12	$2,655.92	$2,114.23	$1,889.24
Plan features					
Primary Care Physician (PCP)	Not Required	Not Required	Not Required	Not Required	Not Required
Referrals	Not Required	Not Required	Not Required	Not Required	Not Required
Out of network benefits	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 60%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Out of area benefits	Coverage provided worldwide through our BlueCard® Network	Coverage provided worldwide through our BlueCard® Network	Coverage provided worldwide through our BlueCard® Network	Coverage provided worldwide through our BlueCard® 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	Qualified dependents are covered to age 26	Qualified dependents are covered to age 26	Qualified dependents are covered to age 26
Domestic partner	Covered	Covered	Covered	Covered	Covered
Wellness Incentives	ThriveWell, a digital home base dedicated to engaging in health and wellbeing. This digital hub will	ThriveWell, a digital home base dedicated to engaging in health and wellbeing. This digital hub will	ThriveWell, a digital home base dedicated to engaging in health and wellbeing. This digital hub will	ThriveWell, a digital home base dedicated to engaging in health and wellbeing. This digital hub will	ThriveWell, a digital home base dedicated to engaging in health and wellbeing. This digital hub will

	SimplyBlue Plus Gold 5	SimplyBlue Plus Gold 17	SimplyBlue Plus Silver 19	SimplyBlue Plus Bronze 4	SimplyBlue Plus Bronze 7
	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.	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.	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.	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.	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**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Primary Care Office Visit	$40 copay per visit	$40 copay per visit	$10 copay per visit, subject to deductible for diagnostic visits $25 copay per visit, subject to deductible for other services performed at a pcp	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Specialist Office Visit	$70 copay per visit	$70 copay per visit	$50 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Coinsurance	None	Covered at 80%	Covered at 100%	Covered at 100%	Covered at 100%
Deductible	None	In-Network: $1,100 Individual / $2,200 Family	In-Network: $3,600 Individual / $7,200 Family	In-Network: $8,500 Individual / $17,000 Family	In-Network: $10,600 Individual / $21,200 Family
Out of pocket maximum	In-Network: $9,200 Individual / $18,400 Family	In-Network: $8,250 Individual / $16,500 Family	In-Network: $8,000 Individual / $16,000 Family	In-Network: $8,500 Individual / $17,000 Family	In-Network: $10,600 Individual / $21,200 Family
Lifetime maximum	None	None	None	None	None
Plan Benefits					
Preventive Healthcare Services	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Well child visits	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full
Adult routine physical exams	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full
+Adult immunizations	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full
+Mammography	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full
+Pap smear	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full
Routine GYN Exam	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full
+Prostate cancer screening	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full
+Colonoscopy	Preventive screenings covered in full	Preventive screenings covered in full	Preventive screenings covered in full	Preventive screenings covered in full	Preventive screenings covered in full
+Family Planning Services	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full
Physician Office Services	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Diagnostic Visits	$40 PCP copay; $70 Specialist copay per visit	$40 PCP copay; $70 Specialist copay per visit	$10 PCP copay; $50 Specialist copay per visit, subject to deductible.	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 Teledermatology $70 copay per visit	Acute and Behavioral Health, & Digital Physical Therapy covered in full Teledermatology $70 copay per visit	Acute and Behavioral Health, & Digital Physical Therapy covered in full, subject to the deductible Teledermatology $50 copay per visit, subject to the deductible	Acute and Behavioral Health, & Digital Physical Therapy covered in full, subject to the deductible Teledermatology Covered at 100%, subject to the deductible	Acute and Behavioral Health, & Digital Physical Therapy covered in full, subject to the deductible Teledermatology $0 copay per visit, subject to the deductible

	SimplyBlue Plus Gold 5	SimplyBlue Plus Gold 17	SimplyBlue Plus Silver 19	SimplyBlue Plus Bronze 4	SimplyBlue Plus Bronze 7
Diagnostic x-rays	$70 copay per visit	$70 copay per visit	$50 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	$100 copay per visit	$100 copay per visit, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Diagnostic laboratory and pathology	$70 copay per visit	$40 copay per visit	$25 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Allergy tests	$40 PCP copay; $70 Specialist copay per visit	$40 PCP copay; $70 Specialist copay per visit	$25 PCP copay; $50 Specialist copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Allergy injections	$40 PCP copay; $70 Specialist copay per visit	$40 PCP copay; $70 Specialist copay per visit	$25 PCP copay; $50 Specialist copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Chemotherapy	$40 copay per visit	$40 copay per visit	$25 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Radiation therapy	$70 copay per visit	$70 copay per visit	$50 Specialist copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Maternity Services	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Prenatal care	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)
Hospital care for mom (including delivery)	Subject to $1,500 copay per admission	Covered at 80%, subject to the deductible	Subject to $500 copay per admission, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Newborn nursery care	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Prescription Drug	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Prescription Drug Coverage	$15/40%/50% $0 generics for kids up to age 19	$10/$45/$90 $0 generics for kids up to age 19	$5/$45/$90, 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.	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.	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.
Diabetic drugs, insulin, and supplies	$40 copay per 30 day supply Insulin: Covered in full	$40 copay per 30 day supply Insulin: Covered in full	$25 copay, subject to deductible per 30 day supply Insulin: Covered in full	Covered at 100%, subject to the deductible Insulin: Covered in full	Covered at 100%, subject to the deductible Insulin: Covered in full
Inpatient Hospital Benefits	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-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	Subject to $500 copay per admission for unlimited days, subject to the deductible	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 In Full	Covered at 80%, subject to the deductible	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Inpatient physical rehabilitation	Subject to $1,500 copay per admission for up to 60 days per contract year	Covered at 80% per 60 day stay per admission per contract year, subject to the deductible	Subject to $500 copay per admission for up to 60 days per per contract year, subject to the deductible	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 In Full	Covered at 80%, subject to the deductible	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible

	SimplyBlue Plus Gold 5	SimplyBlue Plus Gold 17	SimplyBlue Plus Silver 19	SimplyBlue Plus Bronze 4	SimplyBlue Plus Bronze 7
Anesthesia	Covered In Full	Covered at 80%, subject to the deductible	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Emergency Care	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Emergency room care	$650 copay per visit	$300 copay per visit	$350 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Freestanding urgent care center	$70 copay per visit	$70 copay per visit	$50 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Ambulance	$650 copay	$300 copay per visit	$350 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Outpatient Hospital Benefits	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Diagnostic x-rays	$70 copay per visit	$70 copay per visit	$50 copay per visit, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	$100 copay per visit	$100 copay per visit, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Diagnostic laboratory and pathology	$70 copay per visit	$40 copay per visit	$25 copay per visit, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Surgical Care Facility Fee	$650 copay per visit	Covered at 80%, subject to the deductible	$350 copay per visit; subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Chemotherapy	$40 copay per visit	$40 copay per visit	$25 copay per visit, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Radiation Therapy	$70 copay per visit	$70 copay per visit	$50 copay per visit, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Mental Health and Substance Use	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-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	Subject to $500 copay per admission for unlimited days, subject to the deductible	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	Covered in Full	Covered In Full, subject to deductible	Covered In Full, subject to deductible	Covered In Full, subject to 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	Subject to $500 copay per admission for unlimited days, subject to the deductible	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	Covered in Full	Covered In Full, subject to deductible	Covered In Full, subject to deductible	Covered In Full, subject to deductible
Other Services	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Skilled nursing facility	Subject to $1,500 copay per admission for up to 200 days per year	Covered at 80% per admission for 200 days per year, subject to the deductible	Subject to $500 copay per admission for up to 200 days per year, subject to the deductible	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	$40 copay per visit for 40 visits per year	Covered at 80% for up to 40 visits per year, subject to the deductible	$25 copay per visit for 40 visits per year, subject to the deductible	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	Subject to $1,500 copay per admission for up to 210 days per year	Covered at 80% for up to 210 visits per year, subject to the deductible	Subject to $500 copay per admission for up to 210 days per year, subject to the deductible	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	$40 per visit for physical, speech and occupational therapy for up to 60	$40 for physical, speech and occupational therapy for up to 60	$25 per visit, subject to deductible for physical, speech and occupational	Covered at 100%, subject to the deductible for physical, speech and	Covered at 100%, subject to the deductible for physical, speech and

	SimplyBlue Plus Gold 5	SimplyBlue Plus Gold 17	SimplyBlue Plus Silver 19	SimplyBlue Plus Bronze 4	SimplyBlue Plus Bronze 7
	visits per contract year	visits per contract year	therapy for up to 60 visits per contract year	occupational therapy for up to 60 visits per contract year	occupational therapy for up to 60 visits per contract year
Durable medical equipment	Covered at 50%	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
External prosthetics	Covered at 50%	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Chiropractic	$40 copay per visit	$40 copay per visit	$25 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Acupuncture	$40 copay per visit 10 visits per benefit period	$40 copay per visit 10 visits per benefit period	$25 copay per visit, subject to deductible 10 visits per benefit period	Covered at 100%, subject to the deductible 10 visits per benefit period	Not Covered
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	Covered at 50% , 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	Covered at 100% , subject to the deductible for a single purchase once every 3 years
Vision Benefits	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Adult Routine Vision Exam	One routine exam covered in full per year	One routine exam covered in full per year	One routine exam covered in full per year, subject to the deductible	One routine exam covered in full per year, subject to the deductible	Not Covered
Adult Diagnostic Vision	$70 copay per visit	$70 copay per visit	$50 copay per visit, subject to deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
Adult Eyewear	Eyewear Reimbursement of $100 per year	Eyewear Reimbursement of $100 per year	Eyewear Reimbursement of $100 per year	Eyewear Reimbursement of $100 per year	Not Covered
Pediatric Routine Vision Exam	One routine exam covered in full per year	One routine exam covered in full per year	One routine exam covered in full per year, subject to the deductible	One routine exam covered in full per year, subject to the deductible	One routine exam covered in full per 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	Covered at 50%, subject to the deductible for one purchase per plan year	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
Dental Benefits	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Adult Dental Care	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventive & Routine	Preventive covered at 100%. Routine covered at 80%	Preventive covered at 100%. Routine covered at 80%, subject to the deductible	Preventive cleaning and exams not subject to the deductible. Preventive services covered at 100%, subject to the deductible. Routine services covered at 80%, subject to the deductible	Preventive cleaning and exams not subject to the deductible. Preventive services covered at 100%, subject to the deductible. Routine services covered at 100%, subject to the deductible	Preventive cleaning and exams not subject to the deductible. Preventive services covered at 100%, subject to the deductible. Routine services covered at 100%, subject to the deductible
Pediatric Major Dental Care & Medical Ortho	Covered at 50%	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible
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	$350 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 100% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	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.

Excellus BlueCross BlueShield is a nonprofit independent licensee of the Blue Cross Blue Shield Association