Funding Source	Grant Name	Contract number	Start Date	End Date	Total Grant Dollars	State/Fed Award	Financial Expenditure to Date	ONTSWCD Financial Billable	Hours Committed	Hours Expenditure to Date	Date of Last Query	Status	25% Voucher	65% Voucher	50% Voucher
AgNPS Round 23	Canandaigua Outlet Waste Storage Project	C701321	7/25/2017	12/31/2020	$ 736,788.00	$ 380,034.00	$ -	$ 26,880.00	720	92.5	7/29/2019	Procurement	X	X	
AgNPS Round 24	Mud Creek Erosion Control Project	C701378	11/27/2018	3/1/2022	$ 200,820.00	$ 152,555.00	$ -	$ 12,260.00	300	113	7/29/2019	Procurement/Implementation	X	X	
CRF Rd 2	Finger Lakes Cover Crop Implementation Project	T011797	4/13/2017	12/31/2020	$ 80,080.00	$ 44,790.00	$ 12,709.00	$ 11,010.00	202	114.5	7/29/2019	Implementation	X	X	
CRF Rd 3	Finger Lakes Cover Crop Implementation Project I	C011913	4/27/2018	12/31/2021	$ 232,504.00	$ 119,907.00	$ 37,149.00	$ 8,460.00	230	76	7/29/2019	Implementation	X	X	
CAFO Waste Storage &	Reedland Farm	C011851	12/18/2017	3/1/2021	$ 728,964.00	$ 300,000.00	$ 94,550.67	$ 10,000.00	266	182.25	7/29/2019	Close out	X	X	
CAFO Waste Storage &	V. DeBoover Farm	C011852	12/18/2017	3/1/2021	$ 660,593.36	$ 385,000.00	$ -	$ 10,000.00	266	29	7/29/2019	Procurement	X	X	
CAFO Waste Storage &	Landmark Farms	C011853	12/18/2017	3/1/2021	$ 783,544.69	$ 385,000.00	$ -	$ 10,000.00	266	23.75	7/29/2019	On Hold			
FLX EBM	Green View Farm	LOA0278	7/1/2019	6/30/2021	$ 12,500.00	$ 9,625.00	$ -	$ 1,000.00	23	2	7/29/2019	Procurement	X		
FLX EBM	Rockefeller Farm	LOA0281	7/1/2019	6/30/2021	$ 13,125.00	$ 10,000.00	$ -	$ 625.00	14	2	7/29/2019	Procurement	X		
FLX EBM	Bay Farm		7/1/2019	6/30/2021	$ 8,500.00	$ 6,750.00	$ -	$ 1,500.00	35	0	7/29/2019				
GLRI	Genesee River Watershed GLRI					$ 100,000.00				19	7/29/2019				
WQIP Rd 12	Honeoye Inlet Restoration Project	C00083GG	5/1/2015	4/30/2020	$ 400,000.00	$ 300,000.00	$ 233,871.10	$ 15,000.00	NA		7/29/2019				
WQIP Rd 15	Sandy Bottom Shoreline Restoration Project	T00700GG	5/1/2018	12/31/2020	$ 41,684.00	$ 30,000.00		$ 3,000.00	NA		7/29/2019				
FLLOWPA	Davie Farm Water Retention Basin Project	Res No. 280-2019	5/9/2019		$ 19,900.00	$ 12,900.00		$ 500.00	NA		7/29/2019				
FLLOWPA	Reed Farm Water Retention Project	Res No. 279-2019	5/9/2019		$ 27,900.00	$ 11,900.00		$ 500.00	NA		7/29/2019				

uote Effective: 10/01/2019 - 12/31/2019

ersion Updated: 06/28/2019

ating Region: Rochester

New Plan 2019 | CURRENT PLAN - 3% increase | New Plan 2019

	SimplyBlue Plus Silver 18		SimplyBlue Plus Silver 2		SimplyBlue Plus Silver 19	
Plan Overview						
Plan ID	78124NY0990313-00 (SML1)		78124NY1000057-00 (SNC7)		78124NY1000297-00 (SMM7)	
Plan Name	SimplyBlue Plus Silver 18		SimplyBlue Plus Silver 2		SimplyBlue Plus Silver 19	
Aggregation Design	Individual Aggregation		Family Aggregation		Family Aggregation	
Plan Highlights	A deductible is applied to select covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full, includes ExerciseRewards.		A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full, includes ExerciseRewards.		A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full, includes ExerciseRewards.	
Plan Type	Hybrid		Deductible HSA		Deductible HSA	
HSA Eligible	No		Yes		Yes	
Quote Effective	10/01/2019 - 12/31/2019		10/01/2019 - 12/31/2019		10/01/2019 - 12/31/2019	
Rate ($)	**Small Group**		**Small Group**		**Small Group**	
Single	$495.37		$499.42		$498.34	
Subscriber & Spouse	$990.74		$998.84		$996.68	
Subscriber & Child(ren)	$842.13		$849.01		$847.18	
Family	$1,411.80		$1,423.35		$1,420.27	
Plan features						
Primary Care Physician (PCP)	Not Required		Not Required		Not Required	
Referrals	Not Required		Not Required		Not Required	
Out of network benefits	Covered at 50%, subject to the deductible		Covered at 50%, subject to the deductible		Covered at 60%, 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	
Student/Dependent coverage	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	
Wellness Incentives	ExerciseRewards® receive $600 a year toward qualified fitness facility dues and/or fitness classes and save on Gym memberships with Active&Fit Direct™.		ExerciseRewards® receive $600 a year toward qualified fitness facility dues and/or fitness classes and save on Gym memberships with Active&Fit Direct™.		ExerciseRewards® receive $600 a year toward qualified fitness facility dues and/or fitness classes and save on Gym memberships with Active&Fit Direct™.	
Plan cost-sharing highlights						
Plan cost-sharing	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

	SimplyBlue Plus Silver 16		SimplyBlue Plus Silver 2		SimplyBlue Plus Silver 19	
Highlights						
Primary Care Office Visit	$50 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$25 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Specialist Office Visit	$75 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$50 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Coinsurance	Covered at 70%	Covered at 50%	Covered at 75%	Covered at 50%	Covered at 100%	Covered at 60%
Deductible	In-Network: $6,550 Individual / $13,100 Family	Out-of-Network: $6,550 Individual / $13,100 Family	In-Network: $2,000 Individual / $4,000 Family	Out-of-Network: $2,000 Individual / $4,000 Family	In-Network: $2,250 Individual / $4,500 Family	Out-of-Network: $2,250 Individual / $4,500 Family
Out of pocket maximum	In-Network: $7,500 Individual / $15,000 Family	Out-of-Network: $7,500 Individual / $15,000 Family	In-Network: $6,650 Individual / $13,300 Family	Out-of-Network: $6,650 Individual / $13,300 Family	In-Network: $6,550 Individual / $13,100 Family	Out-of-Network: $6,550 Individual / $13,100 Family
Lifetime maximum	None	None	None	None	None	None
Plan Benefits						
Preventive Healthcare Services	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Well child visits	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
Adult routine physical exams	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
+Adult immunizations	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
+Mammography	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
+Pap smear	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
Routine GYN Exam	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
+Prostate cancer screening	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 50%, subject to the deductible	Covered In Full	Covered at 60%, subject to the deductible
+Colonoscopy	Preventive screenings covered in full	Covered at 50%, subject to the deductible	Preventive screenings covered in full	Covered at 50%, subject to the deductible	Preventive screenings covered in full	Covered at 60%, subject to the deductible
+Family Planning Services	Covered in full	Covered at 50%, subject to the deductible	Covered in full	Covered at 50%, subject to the deductible	Covered in full	Covered at 60%, subject to the deductible
Physician Office Services	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic office visits	$50 PCP copay; $75 Specialist copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$25 PCP copay; $50 Specialist copay per visit, subject to deductible.	Covered at 60%, subject to the deductible
Telemedicine Visits	$50 PCP copay; $75 Specialist copay per visit. MDLive Provider: $10 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible. MDLive Provider: Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$25 PCP copay; $50 Specialist copay per visit, subject to deductible. MDLive Provider: $10 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Diagnostic x-rays	$75 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$50 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Advanced Imaging	$100 copay per visit	Covered at 50%, subject to the	Covered at 75%, subject to the	Covered at 50%, subject to the	$100 copay per visit, subject to	Covered at 60%, subject to the

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Services		deductible	deductible	deductible	the deductible	deductible
Diagnostic laboratory and pathology	$50 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$25 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Allergy tests	$50 PCP copay; $75 Specialist copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$25 PCP copay; $50 Specialist copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Allergy injections	$50 PCP copay; $75 Specialist copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$25 PCP copay; $50 Specialist copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Chemotherapy	$50 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$25 PCP copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Radiation therapy	$75 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$50 PCP copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Maternity Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prenatal care	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered at 50%, subject to the deductible	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered at 50%, subject to the deductible	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered at 60%, subject to the deductible
Hospital care for mom (including delivery)	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	Subject to $500 copay per admission, subject to the deductible	Covered at 60% per admission, subject to the deductible
Newborn nursery care	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	Covered In Full, subject to deductible	Covered at 60% per admission, subject to the deductible
Prescription Drug	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Coverage	$10/$45/$90	Not Covered	$5/$45/$90, subject to the plan deductible. Preventive drugs are not subject to the deductible; they are subject to the applicable copay or coinsurance.	Not Covered	$5/$45/$90, subject to the plan deductible. Preventive drugs are not subject to the deductible; they are subject to the applicable copay or coinsurance.	Not Covered
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital benefits	Covered at 70% per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible	Covered at 75% per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible	Subject to $500 copay per admission for unlimited days, subject to the deductible	Covered at 60% per admission for unlimited days, subject to the deductible
Physician visits in the hospital	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	Covered In Full, subject to deductible	Covered at 60%, subject to the deductible
Inpatient physical rehabilitation	Covered at 70% per 60 day stay per admission per contract year, subject to the deductible	Covered at 50% per 60 day stay per admission per contract year, subject to the deductible	Covered at 75% per 60 day stay per admission per contract year, subject to the deductible	Covered at 50% 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 60% per admission for up to 60 days per contract year, subject to the deductible
Surgery	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	Covered In Full, subject to deductible	Covered at 60%, subject to the deductible
Anesthesia	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	Covered In Full, subject to deductible	Covered at 60%, subject to the deductible
Emergency Care	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency room care	$500 copay per visit	$500 copay per visit	Covered at 75%, subject to the deductible	Covered at 75%, subject to the deductible	$300 copay per visit, subject to deductible	$300 copay per visit, subject to deductible

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Freestanding urgent care center	$75 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$50 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Ambulance	$500 copay per visit	$500 copay per visit	Covered at 75%, subject to the deductible	Covered at 75%, subject to the deductible	$300 copay per visit, subject to deductible	$300 copay per visit, subject to deductible
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic x-rays	$75 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$50 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$100 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Diagnostic laboratory and pathology	$50 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$25 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Surgical Care Facility Fee	Covered at 70%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$300 copay per visit; subject to deductible	Covered at 60%, subject to the deductible
Chemotherapy	$50 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$25 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Radiation Therapy	$75 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$50 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Mental Health and Substance Use	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient mental health care	Covered at 70% per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible	Covered at 75% per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible	Subject to $500 copay per admission for unlimited days, subject to the deductible	Covered at 60% per admission for unlimited days, subject to the deductible
Outpatient mental health care	$75 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$50 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Inpatient substance use	Covered at 70% per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible	Covered at 75% per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible	Subject to $500 copay per admission for unlimited days, subject to the deductible	Covered at 60% per admission for unlimited days, subject to the deductible
Outpatient substance use	$75 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$50 copay per visit, subject to the deductible	Covered at 60%, subject to the deductible
Other Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diabetic drugs, insulin, and supplies	$50 copay per 30 day supply	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$25 copay, subject to deductible per 30 day supply	Covered at 60%, subject to the deductible
Skilled nursing facility	Covered at 70% per admission for 200 days per year, subject to the deductible	Covered at 50% per admission for 200 days per year, subject to the deductible	Covered at 75% per admission for 200 days per year, subject to the deductible	Covered at 50% 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 60% per admission for up to 200 days per year, subject to the deductible
Home care	Covered at 70% for up to 40 visits per year, subject to the deductible	Covered at 50% for up to 40 visits per year, subject to the deductible	Covered at 75% for up to 40 visits per year, subject to the deductible	Covered at 50% 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 60%. for up to 40 visits per year, subject to the deductible
Hospice	Covered at 70% for up to 210 visits per year, subject to the deductible	Covered at 50% for up to 210 visits per year, subject to the deductible	Covered at 75% for up to 210 visits per year, subject to the deductible	Covered at 50% 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 60% for up to 210 visits per year, subject to the deductible
Outpatient therapy	$75 for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 50%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 75%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 50%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	$50 per visit, subject to deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 60%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year

	SimplyBlue Plus Silver 18		SimplyBlue Plus Silver 2		SimplyBlue Plus Silver 19	
Durable medical equipment	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
External prosthetics	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible
Chiropractic	$75 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$50 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Aids	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 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 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
Vision Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Routine Vision Exam	$75 copay per visit for one routine exam every year	Covered at 50% for one routine exam every year, subject to the deductible	Covered at 75% for one routine exam every year, subject to the deductible	Covered at 50% for one routine exam every year, subject to the deductible	$50 copay per visit for one routine exam every year, subject to deductible	Covered at 60% for one routine exam every year, subject to the deductible
Adult Diagnostic Vision	$75 copay per visit	Covered at 50%, subject to the deductible	Covered at 75%, subject to the deductible	Covered at 50%, subject to the deductible	$50 copay per visit, subject to deductible	Covered at 60%, subject to the deductible
Adult Eyewear	Eyewear Reimbursement of $60 per year	Eyewear Reimbursement of $60 per year	Eyewear Reimbursement of $60 per year	Eyewear Reimbursement of $60 per year	Eyewear Reimbursement of $60 per year	Eyewear Reimbursement of $60 per year
Pediatric Routine Vision Exam	$75 copay per visit for one routine exam every year	Covered at 50% for one routine exam every year, subject to the deductible	Covered at 75% for one routine exam every year, subject to the deductible	Covered at 50% for one routine exam every year, subject to the deductible	$50 copay per visit for one routine exam every year, subject to the deductible	Covered at 60% for one routine exam every year, subject to the deductible
Pediatric Eyewear	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 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 50%, subject to the deductible 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**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Preventive covered at 100%. Routine covered at 80%, subject to the deductible	Preventive covered at 100%, subject to balance billing. Routine covered at 80%, subject to the deductible and balance billing	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 80%, subject to the deductible and balance billing	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 80%, subject to the deductible and balance billing
Pediatric Major Dental Care & Medical Ortho	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible and balance billing	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible and balance billing	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible and balance billing
Accidental Dental - Outpatient Surgical	Covered at 70% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 50% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 75% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Covered at 50% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	$300 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 60% 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.