Quote Effective: 07/01/2022 - 09/30/2022

Version Updated: 10/28/2021

Print Package: HIOS ID (Enrollment Code)	**78124NY1020233-00 (TDDQ)**
Plan Name:	**Univera Access Platinum 4**
Rating Region:	**Western NY**
Rate	
For the Benefits described in the Agreement, the Plan will charge and Group will pay the following premium rates:	
Single	$727.24
Subscriber & Spouse	$1,454.48
Subscriber & Child(ren)	$1,236.31
Family	$2,072.63
Dependent Coverage To Age **26**, Pediatric Dental Coverage **Yes**, Domestic Partner Coverage **Yes**, Family Planning Coverage **Yes**	
Rates quoted herein are subject to change due to our implementation of the provisions of the Federal Patient Protection and Affordable Care Act.	
The Sales Representative providing this quote is a New York State licensed insurance producer employed by Univera Health Plan. The individual represents Univera Health Plan in this transaction and will be compensated by Univera Health Plan in part based on this sale. The amount of compensation is based on a number of factors, including the contract selected and the volume of sales. You may request information about the expected compensation from your Sales Representative.	
***The NYS Department of Financial Services has approved our rate filing for quarterly community rates. All Rates will be considered to be on a 12 month period from the effective date of coverage unless otherwise instructed by Univera Health Plan. The above rates are effective for the Initial Term of the Agreement. Rates for any Renewal Term will be provided to Group in a rate renewal notice.**	
Please complete this section if you have selected a plan that does not include pediatric dental coverage. A). Have you obtained dental coverage, not offered by Univera Healthcare, that provides essential pediatric dental benefits through a NY State of Health certified dental plan? **Yes No** B.) If you answered 'yes', please provide the name of the company issuing the essential pediatric dental coverage. _____ If you change this dental coverage at any time, you must notify Univera Healthcare to confirm continued coverage of essential pediatric benefits. If you answered 'no' please be aware the ACA requires essential pediatric dental coverage.	

Application

Summary of Benefits & Coverage

Summary of Benefits and Coverage (SBC) for this product has been received. Group is responsible for distributing the SBC to all eligible employees in accordance with PPACA requirements.

Signature: _____ **Title:** _____ **Date:** _____

Group Name: _____ **Total Employees:** _____ **Total Eligible:** _____

Coverage Effective Date: _____

Broker: _____

	Univera Access Platinum 4	
Plan Overview		
Plan ID	78124NY1020233-00 (TDDQ)	
Plan Name	Univera Access Platinum 4	
Aggregation Design	Individual Aggregation	
Plan Highlights	Predictable out-of-pocket costs without a deductible, includes Wellness Rewards and Dental Rewards. Members have access to our PPO network covering 39 Upstate New York counties.	
Plan Type	Copay	
HSA Eligible	No	
Quote Effective	07/01/2022 - 09/30/2022	
Plan features		
Primary Care Physician (PCP)	Not Required	
Referrals	Not Required	
Out of network benefits	Covered at 80%, subject to the deductible	
Out of area benefits	Services rendered outside of the service area are subject to higher out-of-pocket costs and may be subject to balance billing (excludes emergency and dialysis services).	
Student/Dependent coverage	Qualified dependents are covered to age 26	
Domestic partner	Covered	
Wellness Incentives	All plans include two health & wellness programs! With Univera Wellness Rewards, members receive up to $300 a year for programs and services to stay healthy. Plus, a subscriber and eligible spouse can earn $100 annually for getting a dental cleaning and exam with Univera Dental Rewards.	
Plan cost-sharing highlights		
Plan cost-sharing highlights	**In-Network**	**Out-of-Network**
Primary Care Office Visit	$30 copay per visit	Covered at 80%, subject to the deductible
Specialist Office Visit	$50 copay per visit	Covered at 80%, subject to the deductible
Coinsurance	None	Covered at 80%
Deductible	None	Out-of-Network: $5,000 Individual / $10,000 Family
Out of pocket maximum	In-Network: $6,550 Individual / $13,100 Family	Out-of-Network: $10,000 Individual / $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 80%, subject to the deductible
Adult routine physical exams	Covered in full	Covered at 80%, subject to the deductible
+Adult immunizations	Covered in full	Covered at 80%, subject to the deductible
+Mammography	Covered in full	Covered at 80%, subject to the deductible
+Pap smear	Covered in full	Covered at 80%, subject to the deductible
Routine GYN Exam	Covered in full	Covered at 80%, subject to the deductible
+Prostate cancer	Covered in full	Covered at 80%, subject to the deductible

	Univera Access Platinum 4	
screening		
+Colonoscopy	Preventive screenings covered in full	Covered at 80%, subject to the deductible
+Family Planning Services	Covered in full	Covered at 80%, subject to the deductible
Physician Office Services	**In-Network**	**Out-of-Network**
Diagnostic office visits	$30 PCP copay; $50 Specialist copay per visit	Covered at 80%, subject to the deductible
Telemedicine and Telehealth Services	Covered in full	Covered at 80%, subject to the deductible
Diagnostic x-rays	$50 copay per visit	Covered at 80%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	$30 copay per visit	Covered at 80%, subject to the deductible
Allergy tests	$30 PCP copay; $50 Specialist copay per visit	Covered at 80%, subject to the deductible
Allergy injections	$30 PCP copay; $50 Specialist copay per visit	Covered at 80%, subject to the deductible
Chemotherapy	$30 copay per visit	Covered at 80%, subject to the deductible
Radiation therapy	$50 copay per visit	Covered at 80%, subject to the 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 the deductible per admission
Hospital care for mom (including delivery)	Subject to $750 copay per admission	Covered at 80%, per admission, subject to the deductible
Newborn nursery care	Covered in full	Covered at 80%, per admission, subject to the deductible
Prescription Drug	**In-Network**	**Out-of-Network**
Prescription Drug Coverage	$5/$35/$70	Not Covered
Diabetic drugs, insulin, and supplies	$30 copay per 30 day supply	Covered at 80%, subject to the deductible
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Hospital benefits	Subject to $750 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible
Physician visits in the hospital	Covered in full	Covered at 80%, subject to the deductible per admission
Inpatient physical rehabilitation	Subject to $750 copay per admission for up to 60 days per contract year	Covered at 80%, per admission for up to 60 days per contract year, subject to the deductible
Surgery	Covered in full	Covered at 80%, subject to the deductible
Anesthesia	Covered in full	Covered at 80%, subject to the deductible per admission
Emergency Care	**In-Network**	**Out-of-Network**
Emergency room care	$250 copay per visit	$250 copay per visit
Freestanding urgent care center	$50 copay per visit	Covered at 80%, subject to the deductible
Ambulance	$250 copay	$250 copay
Outpatient Hospital	**In-Network**	**Out-of-Network**

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Benefits		
Diagnostic x-rays	$50 copay per visit	Covered at 80%, subject to the deductible
Advanced Imaging Services	$100 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	$30 copay per visit	Covered at 80%, subject to the deductible
Surgical Care Facility Fee	$250 copay per visit	Covered at 80%, subject to the deductible
Chemotherapy	$30 copay per visit	Covered at 80%, subject to the deductible
Radiation Therapy	$50 copay per visit	Covered at 80%, subject to the deductible
Mental Health and Substance Use	**In-Network**	**Out-of-Network**
Inpatient mental health care	Subject to $750 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible
Outpatient mental health care	3 visits covered in full. Next visits covered at $30 copay per visit	Covered at 80%, subject to the deductible
Inpatient substance use	Subject to $750 copay per admission for unlimited days	Covered at 80%, per admission for unlimited days, subject to the deductible
Outpatient substance use	3 visits covered in full. Next visits covered at $30 copay per visit	Covered at 80%, subject to the deductible
Other Services	**In-Network**	**Out-of-Network**
Skilled nursing facility	Subject to $750 copay per admission for up to 200 days per year	Covered at 80%, per admission for up to 200 days per year, subject to the deductible
Home care	$30 copay per visit for 40 visits per year	Covered at 80%, for up to 40 visits per year, subject to the deductible
Hospice	Subject to $750 copay per admission for up to 210 days per year	Covered at 80%, for up to 210 days per year, subject to the deductible
Outpatient therapy	$50 per visit for physical, speech and occupational therapy for up to 60 visits per contract year	Covered at 80%, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year
Durable medical equipment	Covered at 50%	Covered at 50%, subject to the deductible
External prosthetics	Covered at 50%	Covered at 50%, subject to the deductible
Chiropractic	$30 PCP copay	Covered at 80%, subject to the deductible
Acupuncture	Not Covered	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
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	$50 copay per visit	Covered at 80%, subject to the deductible
Adult Eyewear	Eyewear reimbursement of $100 per year	Eyewear reimbursement of $100 per year
Pediatric Routine Vision Exam	$50 copay per visit for one routine exam every year	Covered at 80% for one routine exam every 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
Dental Benefits	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Preventive covered at 100%. Routine covered at 80%	Preventive covered at 100%, subject to balance billng. Routine covered at 80%,subject to the deductible and balance billing
Pediatric Major Dental	Covered at 50%	Covered at 50%, subject to the deductible and balance billing

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Care & Medical Ortho		
Accidental Dental - Outpatient Surgical	$250 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