Quote Effective: 10/01/2022 - 12/31/2022

Version Updated: 10/28/2021

Print Package: HIOS ID (Enrollment Code)	**78124NY1020249-00 (TKKM)**
Plan Name:	**Univera Clear Options Gold**
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	$644.36
Subscriber & Spouse	$1,288.72
Subscriber & Child(ren)	$1,095.41
Family	$1,836.43
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.	

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

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

Coverage Effective Date: _____

Broker: _____

	Univera Clear Options Gold	
Plan ID	78124NY1020249-00 (TKKM)	
Plan Name	Univera Clear Options Gold	
LEVEL SUMMARY		
	Cost / Benefits	
Level 1 Cost / Benefits	$0 / Preventive Services	
Level 2 Cost / Benefits	$50 / Primary Care Visit, Facility Lab	
Level 3 Cost / Benefits	$100 / Specialist Visit, X-ray, Urgent Care	
Level 4 Cost / Benefits	$200 / Emergency Room Visit, Advanced Imaging, DME	
Level 5 Cost / Benefits	$1,000 / Outpatient Surgery	
Level 6 Cost / Benefits	$6,500 / Inpatient Hospitalization, Skilled Nursing Facility	
OOPM Single / Family	$6,500 / $13,000	
Plan Overview		
Aggregation Design	Individual Aggregation	
Plan Highlights	New budget-friendly copay option with easy-to-understand, predictable health care costs. Includes Wellness Rewards and Dental Rewards.	
Plan Type	Copay	
HSA Eligible	No	
Quote Effective	10/01/2022 - 12/31/2022	
Plan features		
Primary Care Physician (PCP)	Not Required	
Referrals	Not Required	
Out of network benefits	Subject to copay dependent on service	
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	Level 2 - up to $50 copay per visit	Level 2 OON $75 copay per visit, subject to balance billing
Specialist Office Visit	Level 3 - up to $100 copay per visit	Level 3 OON $150 copay per visit, subject to balance billing
Coinsurance	None	None
Deductible	None	None
Out of pocket maximum	In-Network: $6,500 Individual / $13,000 Family	Out-of-Network: $9,750 Individual / $19,500 Family
Lifetime maximum	None	None
Plan Benefits		

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Preventive Healthcare Services	**In-Network**	**Out-of-Network**
Well child visits	Level 1 - Covered In Full	Level 2 OON $75 copay per visit, subject to balance billing
Adult routine physical exams	Level 1 - Covered In Full	Level 2 OON $75 copay per visit, subject to balance billing
+Adult immunizations	Level 1 - Covered In Full	Level 2 OON $75 copay per visit, subject to balance billing
+Mammography	Level 1 - Covered In Full	Level 2 OON $75 copay per visit, subject to balance billing
+Pap smear	Level 1 - Covered In Full	Level 2 OON $75 copay per visit, subject to balance billing
Routine GYN Exam	Level 1 - Covered In Full	Level 2 OON $75 copay per visit, subject to balance billing
+Prostate cancer screening	Level 1 - Covered In Full	Level 2 OON $75 copay per visit, subject to balance billing
+Colonoscopy	Level 1 - Preventive screenings covered in full	Level 2 OON $75 copay per visit, subject to balance billing
+Family Planning Services	Level 1 - Covered In Full	Level 2 OON $75 copay per visit, subject to balance billing
Physician Office Services	**In-Network**	**Out-of-Network**
Diagnostic office visits	Level 2 - up to $50 PCP copay; Level 3 - up to $100 Specialist copay per visit	Level 3 OON $150 copay per visit, subject to balance billing
Telemedicine and Telehealth Services	Level 1 - Covered In Full	Level 3 OON $150 copay per visit, subject to balance billing
Diagnostic x-rays	Level 3 - up to $100 copay per visit	Level 3 OON $150 copay per visit, subject to balance billing
Advanced Imaging Services	Level 4 - up to $200 copay per visit	Level 4 OON $300 copay per visit, subject to balance billing
Diagnostic laboratory and pathology	Level 2 - up to $50 copay per visit	Level 2 OON $75 copay per visit, subject to balance billing
Allergy tests	Level 2 - up to $50 PCP copay; Level 3 - up to $100 Specialist copay per visit	Level 3 OON $150 copay per visit, subject to balance billing
Allergy injections	Level 2 - up to $50 PCP copay; Level 3 - up to $100 Specialist copay per visit	Level 3 OON $150 copay per visit, subject to balance billing
Chemotherapy	Level 2 - up to $50 copay per visit	Level 2 OON $75 copay per visit, subject to balance billing
Radiation therapy	Level 3 - up to $100 copay per visit	Level 3 OON $150 copay per visit, subject to balance billing
Maternity Services	**In-Network**	**Out-of-Network**
Prenatal care	Level 1 - Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Level 2 OON $75 (Cost share may apply to ultrasounds, lab work and sick visits), subject to balance billing
Hospital care for mom (including delivery)	Level 6 - up to $6,500 copay per admission	Level 6 OON $9,750 copay per admission, subject to balance billing
Newborn nursery care	Level 1 - Covered In Full	Level 1 OON Covered In Full, subject to balance billing
Prescription Drug	**In-Network**	**Out-of-Network**
Prescription Drug Coverage	$10/$50/$100	Not Covered
Diabetic drugs, insulin, and supplies	Level 2 - up to $50 copay per 30 day supply	Level 2 OON $75 copay per 30 day supply, subject to balance billing
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Hospital benefits	Level 6 - up to $6,500 copay per admission for unlimited days	Level 6 OON $9,750 copay per admission for unlimited days, subject to balance billing
Physician visits in the	Level 1 - Covered In Full	Level 1 OON - Covered In Full, subject to balance billing

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hospital		
Inpatient physical rehabilitation	Level 6 - up to $6,500 copay per admission for up to 60 days per contract year	Level 6 OON $9,750 copay per admission for up to 60 days per contract year, subject to balance billing
Surgery	Level 1 - Covered In Full	Level 1 OON - Covered In Full, subject to balance billing
Anesthesia	Level 1 - Covered In Full	Level 3 OON $150 copay per visit, subject to balance billing
Emergency Care	**In-Network**	**Out-of-Network**
Emergency room care	Level 4 - up to $200 copay per visit	Level 4 - up to $200 copay per visit
Freestanding urgent care center	Level 3 - up to $100 copay per visit	Level 3 OON $150 copay per visit, subject to balance billing
Ambulance	Level 4 - up to $200 copay per visit	Level 4 - up to $200 copay per visit
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Diagnostic x-rays	Level 3 - up to $100 copay per visit	Level 3 OON $150 copay per visit, subject to balance billing
Advanced Imaging Services	Level 4 - up to $200 copay per visit	Level 4 OON $300 copay per visit, subject to balance billing
Diagnostic laboratory and pathology	Level 2 - up to $50 copay per visit	Level 2 OON $75 copay per visit, subject to balance billing
Surgical Care Facility Fee	Level 5 - up to $1,000 copay per visit	Level 5 OON $1,500 copay per visit, subject to balance billing
Chemotherapy	Level 2 - up to $50 copay per visit	Level 2 OON $75 copay per visit, subject to balance billing
Radiation Therapy	Level 3 - up to $100 copay per visit	Level 3 OON $150 copay per visit, subject to balance billing
Mental Health and Substance Use	**In-Network**	**Out-of-Network**
Inpatient mental health care	Level 6 - up to $6,500 copay per admission for unlimited days	Level 6 OON $9,750 copay per admission for unlimited days, subject to balance billing
Outpatient mental health care	3 visits covered in full. Next visits Level 2 - up to $50 copay per visit	Level 2 OON $75 copay per visit, subject to balance billing
Inpatient substance use	Level 6 - up to $6,500 copay per admission for unlimited days	Level 6 OON $9,750 copay per admission for unlimited days, subject to balance billing
Outpatient substance use	3 visits covered in full. Next visits Level 2 - up to $50 copay per visit	Level 2 OON $75 copay per visit, subject to balance billing
Other Services	**In-Network**	**Out-of-Network**
Skilled nursing facility	Level 6 - up to $6,500 copay per admission for up to 200 days per year	Level 6 OON $9,750 copay per admission for up to 200 days per year, subject to balance billing
Home care	Level 2 - up to $50 copay per visit for 40 visits per year	Level 2 OON $75 copay per visit for 40 visits per year, subject to balance billing
Hospice	Level 4 - up to $200 copay per admission for up to 210 days per year	Level 4 OON $300 copay per admission for up to 210 days per year, subject to balance billing
Outpatient therapy	Level 3 - up to $100 per visit for physical, speech and occupational therapy for up to 60 visits per contract year	Level 3 OON $150 per visit for physical, speech and occupational therapy for up to 60 visits per contract year, subject to balance billing
Durable medical equipment	Level 4 - up to $200	Level 4 OON $300, subject to balance billing
External prosthetics	Level 4 - up to $200	Level 4 OON $300, subject to balance billing
Chiropractic	Level 2 - up to $50 copay per visit	Level 2 OON $75 copay per visit, subject to balance billing
Acupuncture	Not Covered	Not Covered
Hearing Aids	Level 5 - up to $1,000 copay for a single purchase once every 3 years	Level 5 OON $1500 copay for a single purchase once every 3 years, subject to balance billing
Vision Benefits	**In-Network**	**Out-of-Network**

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Adult Routine Vision Exam	Level 1 Covered in Full for one routine exam every year	Level 3 OON $150 copay per visit, subject to balance billing
Adult Diagnostic Vision	Level 3 - up to $100 copay per visit	Level 3 OON $150 copay per visit, subject to balance billing
Adult Eyewear	Level 4 - up to $200 copay. Frames and Lenses OR Contacts - 1 Purchase(s) per benefit period	Level 4 OON $300 copay. Frames and Lenses OR Contacts - 1 Purchase(s) per benefit period, subject to balance billing
Pediatric Routine Vision Exam	Level 3 - up to $100 copay per visit for one routine exam every year	Level 3 OON $150 copay per visit for one routine exam every year, subject to balance billing
Pediatric Eyewear	Level 4 - up to $200 copay. Lenses and Contacts - 1 Purchase(s) per benefit period	Level 4 OON $300 copay. Lenses and Contacts - 1 Purchase(s) per benefit period, subject to balance billing
Dental Benefits	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Preventive covered at Level 2 up to $50. Routine covered at Level 2 up to $50	Preventive covered at Level 2 OON $75, subject to balance billing. Routine covered at Level 2 OON $75, subject to balance billing
Pediatric Major Dental Care & Medical Ortho	Covered at Level 2 up to 50	Covered at Level 2 OON $75, subject to balance billing
Accidental Dental - Outpatient Surgical	Level 5 - up to $1,000 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Level 5 OON $1500 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to balance billing