



Version Updated: 10/28/2021

Print Package: HIOS ID (Enrollment Code)	78124NY1120009-00	78124NY1120009-00 (SZQ3)
Plan Name:	Healthy New York EPO	Healthy New York EPO
Rating Region:	Western NY	Western NY
Rate		
For the Benefits described in the Agreement, the Plan will charge and Group will pay the following premium rates:		
Single	\$459.85	\$506.51
Subscriber & Spouse	\$919.70	\$1,013.02
Subscriber & Child(ren)	\$781.75	\$861.07
Family	\$1,310.57	\$1,443.55
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:

	Healthy New York EPO	Healthy New York EPO		
Plan Overview				
Plan ID	78124NY1120009-00	78124NY1120009-00 (SZQ3)		
Plan Name	Healthy New York EPO	Healthy New York EPO		
Aggregation Design	Individual Aggregation	Individual Aggregation		
Plan Highlights	A deductible is applied to all covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full, includes Wellness Rewards and Dental Rewards. Members have access to our PPO network covering 39 Upstate New York counties.	A deductible is applied to all covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full, includes Wellness Rewards and Dental Rewards. Members have access to our PPO network covering 39 Upstate New York counties.		
Plan Type	Hybrid	Hybrid		
HSA Eligible	No	No		
Quote Effective	07/01/2021 - 09/30/2021	07/01/2022 - 09/30/2022		
Plan features				
Primary Care Physician (PCP)	Not Required	Not Required		
Referrals	Not Required	Not Required		
Out of network benefits	Not Covered	Not Covered		
Out of area benefits	No coverage except for mandated emergency and dialysis services.	No coverage except for mandated emergency and dialysis services.		
Student/Dependent coverage	Qualified dependents are covered to age 26	Qualified dependents are covered to age 26		
Domestic partner	Covered	Covered		
Wellness Incentives	All plans include two Health & Wellness programs! With Univera Wellness Rewards, receive up to \$300 a year for programs and services to help members be healthy. Plus the subscriber and spouse can earn \$100 annually for getting a dental cleaning and exam with Univera Dental Rewards.	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	In-Network	Out-of-Network
Primary Care Office Visit	\$25 copay per visit, subject to deductible	Not Covered	\$25 copay per visit, subject to the deductible	Not Covered
Specialist Office Visit	\$40 copay per visit, subject to deductible	Not Covered	\$40 copay per visit, subject to the deductible	Not Covered
Coinsurance	Applicable where noted	Not Covered	Applicable where noted	Not Covered
Deductible	In-Network: \$600 Individual / \$1,200 Family	Not Covered	In-Network: \$600 Individual / \$1,200 Family	Not Covered
Out of pocket maximum	In-Network: \$4,000 Individual / \$8,000 Family	Not Covered	In-Network: \$4,000 Individual / \$8,000 Family	Not Covered
Lifetime maximum	None	None	None	None
Plan Benefits				
Preventive Healthcare Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Well child visits	Covered In Full	Not Covered	Covered in full	Not Covered
Adult routine physical exams	Covered In Full	Not Covered	Covered in full	Not Covered
+Adult immunizations	Covered In Full	Not Covered	Covered in full	Not Covered
+Mammography	Covered In Full	Not Covered	Covered in full	Not Covered

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+Pap smear	Covered In Full	Not Covered	Covered in full	Not Covered
Routine GYN Exam	Covered In Full	Not Covered	Covered in full	Not Covered
+Prostate cancer screening	Covered In Full	Not Covered	Covered in full	Not Covered
+Colonoscopy	Preventive screenings covered in full	Not Covered	Preventive screenings covered in full	Not Covered
+Family Planning Services	Covered in full	Not Covered	Covered in full	Not Covered
Physician Office Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic office visits	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Not Covered	\$25 PCP copay; \$40 Specialist copay per visit, subject to the deductible	Not Covered
Telemedicine and Telehealth Services	Covered in full, subject to the deductible	Covered at 100%, subject to the deductible	Covered in full, subject to the deductible	Covered at 100%, subject to the deductible
Diagnostic x-rays	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Not Covered	\$25 PCP copay; \$40 Specialist copay per visit, subject to the deductible	Not Covered
Advanced Imaging Services	\$40 copay per visit, subject to the deductible	Not Covered	\$40 copay per visit, subject to the deductible	Not Covered
Diagnostic laboratory and pathology	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Not Covered	\$25 PCP copay; \$40 Specialist copay per visit, subject to the deductible	Not Covered
Allergy tests	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Not Covered	\$25 PCP copay; \$40 Specialist copay per visit, subject to the deductible	Not Covered
Allergy injections	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Not Covered	\$25 PCP copay; \$40 Specialist copay per visit, subject to the deductible	Not Covered
Chemotherapy	\$25 PCP copay per visit, subject to deductible	Not Covered	\$25 PCP copay per visit, subject to the deductible	Not Covered
Radiation therapy	\$25 PCP copay per visit, subject to deductible	Not Covered	\$25 PCP copay per visit, subject to the deductible	Not Covered
Maternity Services	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)	Not Covered	Covered in full (cost share may apply to ultrasounds, lab work and sick visits)	Not Covered
Hospital care for mom (including delivery)	Subject to \$1,000 copay per admission, subject to the deductible	Not Covered	Subject to \$1,000 copay per admission, subject to the deductible	Not Covered
Newborn nursery care	Covered In Full, subject to deductible	Not Covered	Covered in full, subject to the deductible	Not Covered
Prescription Drug	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Coverage	\$10/\$35/\$70	Not Covered	\$10/\$35/\$70	Not Covered
Diabetic drugs, insulin, and supplies	\$25 copay, subject to deductible per 30 day supply	Not Covered	\$25 copay, subject to the deductible per 30 day supply	Not Covered
Inpatient Hospital Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital benefits	Subject to \$1,000 copay per admission for unlimited days, subject to the deductible	Not Covered	Subject to \$1,000 copay per admission for unlimited days, subject to the deductible	Not Covered
Physician visits in the hospital	Covered In Full	Not Covered	Covered in full	Not Covered

	Healthy New York EPO		Healthy New York EPO	
Inpatient physical rehabilitation	Subject to \$1,000 copay per admission for up to 60 days per contract year, subject to the deductible	Not Covered	Subject to \$1,000 copay per admission for up to 60 days per contract year, subject to the deductible	Not Covered
Surgery	\$100 copay per visit, subject to deductible	Not Covered	\$100 copay per visit, subject to the deductible	Not Covered
Anesthesia	Covered In Full	Not Covered	Covered in full	Not Covered
Emergency Care	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency room care	\$150 copay per visit, subject to deductible	\$150 copay per visit, subject to deductible	\$150 copay per visit, subject to the deductible	\$150 copay per visit, subject to the deductible
Freestanding urgent care center	\$60 copay per visit, subject to deductible	Not Covered	\$60 copay per visit, subject to the deductible	Not Covered
Ambulance	\$150 copay per visit, subject to deductible	\$150 copay per visit, subject to deductible	\$150 copay per visit, subject to the deductible	\$150 copay per visit, subject to the deductible
Outpatient Hospital Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic x-rays	\$40 copay per visit, subject to the deductible	Not Covered	\$40 copay per visit, subject to the deductible	Not Covered
Advanced Imaging Services	\$40 copay per visit, subject to the deductible	Not Covered	\$40 copay per visit, subject to the deductible	Not Covered
Diagnostic laboratory and pathology	\$40 copay per visit, subject to the deductible	Not Covered	\$40 copay per visit, subject to the deductible	Not Covered
Surgical Care Facility Fee	\$100 copay per visit; subject to deductible	Not Covered	\$100 copay per visit; subject to deductible	Not Covered
Chemotherapy	\$25 copay per visit, subject to the deductible	Not Covered	\$25 copay per visit, subject to the deductible	Not Covered
Radiation Therapy	\$25 copay per visit, subject to the deductible	Not Covered	\$25 copay per visit, subject to the deductible	Not Covered
Mental Health and Substance Use	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient mental health care	Subject to \$1,000 copay per admission for unlimited days, subject to the deductible	Not Covered	Subject to \$1,000 copay per admission for unlimited days, subject to the deductible	Not Covered
Outpatient mental health care	\$25 copay per visit, subject to the deductible	Not Covered	\$25 copay per visit, subject to the deductible	Not Covered
Inpatient substance use	Subject to \$1,000 copay per admission for unlimited days, subject to the deductible	Not Covered	Subject to \$1,000 copay per admission for unlimited days, subject to the deductible	Not Covered
Outpatient substance use	\$25 copay per visit, subject to the deductible	Not Covered	\$25 copay per visit, subject to the deductible	Not Covered
Other Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Skilled nursing facility	Subject to \$1,000 copay per admission for up to 200 days per year, subject to the deductible	Not Covered	Subject to \$1,000 copay per admission for up to 200 days per year, subject to the deductible	Not Covered
Home care	\$25 copay per visit for 40 visits per year, subject to the deductible	Not Covered	\$25 copay per visit for 40 visits per year, subject to the deductible	Not Covered
Hospice	Subject to \$1,000 copay per admission for up to 210 days per year, subject to the deductible	Not Covered	Subject to \$1,000 copay per admission for up to 210 days per year, subject to the deductible	Not Covered
Outpatient therapy	\$30 per visit, subject to deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Not Covered	\$30 per visit, subject to the deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Not Covered
Durable medical equipment	Covered at 80%, subject to the deductible	Not Covered	Covered at 80%, subject to the deductible	Not Covered
External prosthetics	Covered at 80%, subject to the deductible	Not Covered	Covered at 80%, subject to the deductible	Not Covered
Chiropractic	\$40 Specialist copay per visit, subject to	Not Covered	\$25 PCP copay, subject to the deductible	Not Covered

	Healthy New York EPO		Healthy New York EPO	
	deductible			
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Aids	Covered at 80% , subject to the deductible for a single purchase once every 3 years	Not Covered	Covered at 80% , subject to the deductible for a single purchase once every 3 years	Not Covered
Vision Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Adult Routine Vision Exam	Not Covered	Not Covered	Not Covered	Not Covered
Adult Diagnostic Vision	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Not Covered	\$25 PCP copay; \$40 Specialist copay per visit, subject to the deductible	Not Covered
Adult Eyewear	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Routine Vision Exam	\$25 copay per visit for one routine exam every year, subject to the deductible	Not Covered	\$25 copay per visit for one routine exam every year, subject to the deductible	Not Covered
Pediatric Eyewear	Covered at 80%, subject to the deductible for one purchase per plan year	Not Covered	Covered at 80%, subject to the deductible for one purchase per plan year	Not Covered
Dental Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Adult Dental Care	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	\$25 per visit, subject to deductible	Not Covered	\$25 per visit, subject to the deductible	Not Covered
Pediatric Major Dental Care & Medical Ortho	\$25 per visit, subject to deductible	Not Covered	\$25 per visit, subject to the deductible	Not Covered
Accidental Dental - Outpatient Surgical	\$100 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Not Covered	\$100 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Not Covered

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.