



I Squared R Element Co., Inc.

<b>Print Package: HIOS ID (Enrollment Code)</b>	<b>78124NY1040425-00 (TEQ2)</b>
<b>Plan Name:</b>	<b>Univera Access Silver 5</b>
<b>Rating Region:</b>	<b>Western NY</b>
<b>Rate</b>	
<b>For the Benefits described in the Agreement, the Plan will charge and Group will pay the following premium rates:</b>	
Single	\$611.88
Subscriber & Spouse	\$1,223.76
Subscriber & Child(ren)	\$1,040.20
Family	\$1,743.86
Dependent Coverage To Age 26, Pediatric Dental Coverage <b>Yes</b> , Domestic Partner Coverage <b>Yes</b> , Family Planning Coverage <b>Yes</b>	
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.	
<b>*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.</b>	

**Signature:** \_\_\_\_\_

**Title:**

**Date:**

**Group Name:**

**Total Employees:**

**Total Eligible:**

**Coverage Effective Date:**

**Broker:**

Univera Access Silver 5		
<b>Plan Overview</b>		
Plan ID	78124NY1040425-00 (TEQ2)	
Plan Name	Univera Access Silver 5	
Aggregation Design	Blended Aggregation	
Plan Highlights	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. New for 2024, plan now includes Vitalize. Members have access to our PPO network covering 39 Upstate New York counties.	
Plan Type	Deductible HSA	
HSA Eligible	Yes	
Quote Effective	04/01/2024 - 06/30/2024	
<b>Plan features</b>		
Primary Care Physician (PCP)	Not Required	
Referrals	Not Required	
Out of network benefits	Covered at 50%, 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	New in 2024: Vitalize, powered by Virgin Pulse, will be embedded in all plans, offering rewards of up to \$200 per subscriber and \$200 per spouse, or domestic partner, for a total rewards payout of up to \$400 per plan year.	
<b>Plan cost-sharing highlights</b>		
<b>Plan cost-sharing highlights</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Primary Care Office Visit	\$25 copay and \$0 PCP copay for members to age 19 per visit, subject to the deductible	Covered at 50%, subject to the deductible
Specialist Office Visit	\$50 Specialist copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Coinsurance	Applicable where noted	Covered at 50%
Deductible	In-Network: \$3,250 Individual / \$6,500 Family	Out-of-Network: \$5,000 Individual / \$10,000 Family
Out of pocket maximum	In-Network: \$7,500 Individual / \$15,000 Family	Out-of-Network: \$10,000 Individual / \$20,000 Family
Lifetime maximum	None	None
<b>Plan Benefits</b>		
<b>Preventive Healthcare Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Well child visits	Covered in full	Covered at 50%, subject to the deductible
Adult routine physical exams	Covered in full	Covered at 50%, subject to the deductible
+Adult immunizations	Covered in full	Covered at 50%, subject to the deductible
+Mammography	Covered in full	Covered at 50%, subject to the deductible
+Pap smear	Covered in full	Covered at 50%, subject to the deductible
Routine GYN Exam	Covered in full	Covered at 50%, subject to the deductible

<b>Univera Access Silver 5</b>		
+Prostate cancer screening	Covered in full	Covered at 50%, subject to the deductible
+Colonoscopy	Preventive screenings covered in full	Covered at 50%, subject to the deductible
+Family Planning Services	Covered in full	Covered at 50%, subject to the deductible
<b>Physician Office Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Diagnostic Visits - In-Person or Virtual	\$25 PCP copay and \$0 PCP copay for members to age 19; \$50 Specialist copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Telemedicine with MDLive	Covered in full, subject to the deductible	Covered at 50%, subject to the deductible
Diagnostic x-rays	\$50 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Advanced Imaging Services	\$100 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Diagnostic laboratory and pathology	\$50 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Allergy tests	\$25 PCP copay; \$50 Specialist copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Allergy injections	\$25 PCP copay; \$50 Specialist copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Chemotherapy	\$25 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Radiation therapy	\$50 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
<b>Maternity Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Prenatal care	Covered in full (cost share may apply to ultrasounds, lab work and sick visits)	Covered at 50%, subject to the deductible
Hospital care for mom (including delivery)	Subject to \$1,000 copay per admission, subject to the deductible	Covered at 50% per admission, subject to the deductible
Newborn nursery care	Covered in full, subject to the deductible	Covered at 50% per admission, subject to the deductible
<b>Prescription Drug</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Prescription Drug Coverage	\$15/\$45/\$90, subject to the plan deductible. Preventive drugs are not subject to the deductible; they are subject to the applicable copay.	Not Covered
Diabetic drugs, insulin, and supplies	\$25 copay, subject to the deductible per 30 day supply	Covered at 50%, subject to the deductible
<b>Inpatient Hospital Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Hospital benefits	Subject to \$1,000 copay per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible
Physician visits in the hospital	Covered in full, subject to the deductible	Covered at 50%, subject to the deductible
Inpatient physical rehabilitation	Subject to \$1,000 copay per admission for up to 60 days per contract year, subject to the deductible	Covered at 50%, per admission for up to 60 days per contract year, subject to the deductible
Surgery	Covered in full, subject to the deductible	Covered at 50%, subject to the deductible
Anesthesia	Covered in full, subject to the deductible	Covered at 50%, subject to the deductible
<b>Emergency Care</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Emergency room care	\$350 copay per visit, subject to the deductible	\$350 copay per visit, subject to the deductible
Freestanding urgent care center	\$75 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Ambulance	\$350 copay per visit, subject to the deductible	\$350 copay per visit, subject to the deductible

Univera Access Silver 5		
Outpatient Hospital Benefits	In-Network	Out-of-Network
Diagnostic x-rays	\$50 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Advanced Imaging Services	\$100 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Diagnostic laboratory and pathology	\$50 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Surgical Care Facility Fee	\$350 copay per visit; subject to deductible	Covered at 50%, subject to the deductible
Chemotherapy	\$25 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Radiation Therapy	\$50 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Mental Health and Substance Use	In-Network	Out-of-Network
Inpatient mental health care	Subject to \$1,000 copay per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible
Outpatient mental health care	Covered in full, subject to the deductible	Covered at 50%, subject to the deductible
Inpatient substance use	Subject to \$1,000 copay per admission for unlimited days, subject to the deductible	Covered at 50% per admission for unlimited days, subject to the deductible
Outpatient substance use	Covered in full, subject to the deductible	Covered at 50%, subject to the deductible
Other Services	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	Covered at 50% per admission for up to 200 days per year, subject to the deductible
Home care	\$25 copay per visit for 40 visits per year, subject to the deductible	Covered at 50%. for up to 40 visits per year, subject to the deductible
Hospice	Subject to \$1,000 copay per admission for up to 210 days per year, subject to the deductible	Covered at 50% for up to 210 visits per year, subject to the deductible
Outpatient therapy	\$25 per visit, 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
Durable medical equipment	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
Chiropractic	\$25 PCP copay, subject to the deductible	Covered at 50%, subject to the deductible
Acupuncture	\$25 PCP copay, subject to the deductible	Covered at 50%, subject to the deductible
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
Vision Benefits	In-Network	Out-of-Network
Adult Routine Vision Exam	One routine exam covered in full per year, subject to the deductible	Covered at 50% for one routine exam every year, subject to the deductible
Adult Diagnostic Vision	\$50 copay per visit, subject to the deductible	Covered at 50%, subject to the deductible
Adult Eyewear	Eyewear reimbursement of \$100 per year	Eyewear reimbursement of \$100 per year
Pediatric Routine Vision Exam	One routine exam covered in full per year, subject to the deductible	Covered at 50% 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
Dental Benefits	In-Network	Out-of-Network
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	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

Univera Access Silver 5		
Pediatric Major Dental Care & Medical Ortho	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible and balance billing
Accidental Dental - Outpatient Surgical	\$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 50% 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.