**SECTION IV­**

**Cost-Sharing Expenses and Allowed Amount**

*{Drafting Note: Use for individual, small group, and large group coverage.}*

*{Drafting Note: Insert one of the three deductible paragraphs below. Use the first deductible paragraph for plans that do not have a deductible. Use the second deductible paragraph for the standard NYSOH plan and for any plan that covers services when either a person within a family meets the individual deductible or family members collectively meet the family deductible (embedded deductible). Use the third deductible paragraph when the plan only covers services once family members collectively meet the family deductible (true family deductible).}*

*{Drafting Note: Deductible paragraph one is below. This sentence may be combined with option two or three below if the plan does not have an in-network deductible but has an out-of-network deductible.}*

**A.** [**Deductible.**

There is no Deductible for Covered [in-network] [and out-of-network] Services under this [Certificate; Contract; Policy] during each Plan Year.]

*{Drafting Note: Deductible paragraph two (i.e., embedded deductible) is below.}*

[**Deductible.**

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this [Certificate; Contract; Policy] for Covered [in-network] [and] [out-of-network] Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this [Certificate; Contract; Policy]. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this [Certificate; Contract; Policy] collectively total the family Deductible amount in the Schedule of Benefits section of this [Certificate; Contract; Policy]in a Plan Year, no further Deductible will be required for any person covered under this [Certificate; Contract; Policy] for that Plan Year.

*{Drafting Note: Deductible paragraph three (i.e., true family deductible) is below.}*

[**Deductible.**

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this [Certificate; Contract; Policy] for Covered [in-network] [and] [out-of-network] Services during each Plan Year before We provide coverage. If You have other than individual coverage, You must pay the family Deductible in the Schedule of Benefits section of this [Certificate; Contract; Policy] for Covered [in-network] [and] [out-of-network] Services under this [Certificate; Contract; Policy] during each Plan Year before We provide coverage for any person covered under this [Certificate; Contract; Policy]. However, after Deductible payments for persons covered under this [Certificate; Contract; Policy] collectively total the family Deductible amount in the Schedule of Benefits section of this [Certificate; Contract; Policy]in a Plan Year, no further Deductible will be required for any person covered under this [Certificate; Contract; Policy] for that Plan Year.

*{Drafting Note: The deductible sentences below may be inserted as applicable but may not be used with the standard NYSOH plan.}*

[There are different Deductibles for services provided by Preferred Providers and Participating Providers. The Deductibles for Preferred Providers and Participating Providers apply to Covered in-network Services.] [In-Network Cost-Sharing amounts to which a Deductible applies accumulate toward both the Deductibles for Preferred Providers and for Participating Providers.] [Any in-network Prescription Drugs Covered under this [Certificate; Contract; Policy] are subject to the Preferred Provider Deductible.]

*{Drafting Note:**The paragraph below beginning with “You have a separate; combined” may be included in this section of the certificate; contract; policy or in the out-of-network rider. The paragraph must be included for the standard NYSOH plan, which must have separate in-network and out-of-network deductibles if out-of-network coverage is provided. The first three sentences of the paragraph below should also be included for plans providing out-of-network coverage (including HSA eligible plans) to indicate whether they have separate or combined in-network and out-of-network deductibles. The fourth sentence of the paragraph above must be included for any plan providing out-of-network coverage.}*

[You have a [separate; combined] In-Network and Out-of-Network Deductible. Amounts You pay for out-of-network services [apply; do not apply] toward Your In-Network Deductible. Copayments and Coinsurance for in-network services [apply; do not apply] toward Your Out-of-Network Deductible.] [**Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.**]

*{Drafting Note: Insert the sentence below regarding the January 1 calendar year deductible for individual coverage and group coverage offered outside the NYSOH that has a calendar plan year.}*

[The Deductible runs from January 1 to December 31 of each calendar year.]]

*{Drafting Note:**Plans, other than the standard NYSOH plan, may impose a separate prescription drug deductible.**Plans providing out-of-network coverage must include the bracketed sentences, as applicable, in this section of the certificate; contract; policy or in the out-of-network rider. The sentence beginning with “Amounts You pay for out-of-network services” should be used for plans providing out-of-network coverage that have separate in-network and out-of-network deductibles and for HSA eligible plans. The third sentence of this paragraph must be included for any plan providing out-of-network coverage as applicable.}*

[**Prescription Drug Deductible.**

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this [Certificate; Contract; Policy] for Covered Prescription Drugs during each Plan Year before We provide coverage. [Copayments and Coinsurance for out-of-network services do not apply toward Your In-Network Deductible.] [**Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Prescription Drug Deductible.**]]

*{Drafting Note:**Plans, other than the standard NYSOH plan, may insert the deductible carryover language as applicable.}*

[**Carryover Deductible.**

Amounts that accumulate towards Your Deductible for Covered Services during the last three (3) months in a Plan Year and applied to the Deductible for that Plan Year will also be counted toward Your Deductible for the following Plan Year.]

**B.** **Copayments.**

Except where stated otherwise, [after You have satisfied the Deductible as described above,] You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this [Certificate; Contract; Policy] for Covered [in-network] [and] [out-of-network] Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

**C.** **Coinsurance.**

Except where stated otherwise, [after You have satisfied the Deductible as described above,] You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your [in-network] [or] [out-of-network] benefit as shown in the Schedule ofBenefits section of this [Certificate; Contract; Policy]. [**You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**]

*{Drafting Note: Insert the bracketed language if the plan provides out-of-network coverage.}*

*{Drafting Note: Insert the section below if applicable for the non-standard NYSOH plan and plans offered outside the NYSOH.}*

[**D.**][[**Primary Care; Office Visit; First Dollar**] **Allowance.**

[We Cover Services provided in an office setting for diagnostic evaluation and treatment in full for each Member until the allowance described in the Schedule of Benefits section of this [Certificate; Contract; Policy] is exhausted for a Plan Year. Once the allowance is exhausted, the Cost-Sharing in the Schedule of Benefits section of this [Certificate; Contract; Policy] will apply. Services included in the allowance are those provided by [Your Primary Care Physician] [or] [Your Primary Care Physician whose specialty is exclusively internal medicine, family practice, general practice, OB/GYN or pediatrics].]

[You have a first dollar allowance per Plan Year as shown in the Schedule of Benefits section of this [Certificate; Contract; Policy]. The first dollar allowance amount applies to all Covered [in-network] [and out-of-network] Services. Payments for medical charges for Covered Services are based on Our Allowed Amount. Initial payment will be made from Your first dollar allowance balance, and if Your first dollar allowance will cover the charge in full, there will be no out-of-pocket cost to You. Medical charges that exceed the balance of Your first dollar allowance are subject to the Cost-Sharing listed in the Schedule of Benefits section of this [Certificate; Contract; Policy]. [Any portion of Your first dollar allowance amount not used in the current Plan Year will be credited towards Your first dollar allowance amount for the following Plan Year. First dollar allowance credits will not exceed [two (2)] times the annual allowance amount.]]

Preventive services required to be Covered at no Cost-Sharing do not count toward the allowance.]

[**E.**] [**In-Network**] **Out-of-Pocket Limit.**

When You have met Your [In-Network] Out-of-Pocket Limit in payment of [In-Network] [and Out-of-Network] Cost-Sharing for a Plan Year in the Schedule of Benefits section of this [Certificate; Contract; Policy], We will provide coverage for 100% of the Allowed Amount for Covered [in-network] Services for the remainder of that Plan Year. [If You have other than individual coverage, once a person within a family meets the [individual; per person in a family] [In-Network] Out-of-Pocket Limit in the Schedule of Benefits section of this [Certificate; Contract; Policy], We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person.] If other than individual coverage applies, when persons in the same family covered under this [Certificate; Contract; Policy] have collectively met the family [In-Network] Out-of-Pocket Limit in payment of [In-Network] Cost-Sharing for a Plan Year in the Schedule of Benefits section of this [Certificate; Contract; Policy], We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family. [There are different Out-of-Pocket Limits for services provided by Preferred Providers and Participating Providers. The Out-of-Pocket Limits for Preferred Providers and Participating Providers apply to Covered in-network Services.] [In-network Cost-Sharing amounts to which an Out-of-Pocket Limit applies will accumulate toward both the Out-of-Pocket Limits for Preferred Providers and for Participating Providers.]

*{Drafting Note: Omit the bracketed “in-network”/”In-Network” provisions if the plan does not provide an out-of-network option. Non-standard plans and plans offered outside NYSOH may insert the bracketed “and Out-of-Network” in the first sentence if in-network and out-of-network cost-sharing accumulate towards the out-of-pocket limit. Standard NYSOH plans must insert the first bracketed provision beginning with “If you have other than individual coverage” and use the word “individual” in that sentence. Non-standard plans and plans offered outside the NYSOH should insert the first bracketed provision beginning with “If you have other than individual coverage” and: 1) use the word “individual” when the plan embeds the individual out-of-pocket limit amount (i.e., applies the individual out-of-pocket limit to each person within the family); or 2) use “per person in a family” when the plan embeds an amount other than the individual out-of-pocket limit up to $8,550 (subject to change). Non-standard plans and plans offered outside the NYSOH may remove the first bracketed provision beginning with “If you have other than individual coverage” only if the plan provides coverage in full once family members collectively meet the family out-of-pocket limit (i.e., a true family out-of-pocket limit) and that family limit is less than $8,550 (subject to change).*

*Dividing the maximum amount permitted by the IRS for the out-of-pocket limit into different categories of benefits is permitted for large groups only. If the out-of-pocket limit is divided for large group coverage, insert “for a benefit or set of benefits” in the first sentence after “When You have met Your [In-Network] Out-of-Pocket Limit” and insert “subject to that Out-of-Pocket Limit” after “Allowed Amount for Covered [in-network] Services”.}*

[Cost-Sharing for out-of-network services, except for Emergency Services[,] [and] out-of-network services approved by Us as an in-network exception [and] [out-of-network dialysis] does not apply toward Your [In-Network] Out-of-Pocket Limit.] [The [Preauthorization; notification] penalty described in the How Your Coverage Works section of this [Certificate; Contract; Policy] does not apply toward Your [In-Network] Out-of-Pocket Limit.] [The [In-Network] Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.]

*{Drafting Note: Standard NYSOH plans must include the first sentence. Include the above reference to out-of-network dialysis only if the plan does not provide coverage for out-of-network services. Insert the above reference to the preauthorization penalty when a preauthorization penalty is included in the plan for standard NYSOH plans. The preauthorization penalty language is optional for non-standard NYSOH plans and plans offered outside the NYSOH. Insert the last sentence regarding the January 1 calendar year out-of-pocket limit for individual coverage and group coverage offered outside the NYSOH that has a calendar plan year.}*

*{Drafting Note: Insert the first sentence in the paragraph below for plans that that do not have an out-of-network out-of-pocket limit. Insert the second sentence for plans that have a separate out-of-pocket limit on out-of-network services. The paragraphs below may be included in this section of the certificate; contract; policy or in the out-of-network rider.}*

[**F.**] [**Out-of-Network Out-of-Pocket Limit.**

[This [Certificate; Contract; Policy] does not have [a separate; an] Out-of-Network Out-of-Pocket Limit.] [This [Certificate; Contract; Policy] has a separate Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits section of this [Certificate; Contract; Policy] for out-of-network benefits. When You have met Your Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this [Certificate; Contract; Policy], We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the remainder of that Plan Year. [If You have other than individual coverage, once a person within a family meets the [individual; per person within a family] Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits section of this [Certificate; Contract; Policy], We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the rest of that Plan Year for that person.] If other than individual coverage applies, when persons in the same family covered under this [Certificate; Contract; Policy] have collectively met the family Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this [Certificate; Contract; Policy], We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the rest of that Plan Year for the entire family. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward Your Out-of-Network Out-of-Pocket Limit.**]

*{Drafting Note: Insert the bracketed language beginning with “If You have other than individual coverage” and: 1) use the word “individual” when the plan embeds the individual out-of-network out-of-pocket limit amount (i.e., applies the individual out-of-network out-of-pocket limit to each person within the family); or 2) use “per person within a family” when the plan embeds an amount other than the individual out-of-network out-of-pocket limit. Plans may remove the first bracketed provision beginning with “If you have other than individual coverage” if the plan provides coverage in full once family members collectively meet the family out-of-network out-of-pocket limit (i.e., a true family out-of-pocket limit).}*

[Cost-Sharing for in-network services does not apply toward Your Out-of-Network Out-of-Pocket Limit.] [The [Preauthorization; notification] penalty described in the How Your Coverage Works section of this [Certificate; Contract; Policy] does not apply toward Your Out-of-Network Out-of-Pocket Limit.] [The Out-of-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.]]

*{Drafting Note: Insert the first bracketed sentence beginning with “Cost-Sharing for in-network services” as applicable. Insert the second sentence above when a preauthorization penalty is included in the plan for standard NYSOH plans. The preauthorization penalty language is optional for non-standard NYSOH plans and plans offered outside the NYSOH. Insert the last sentence regarding the January 1 calendar year out-of-pocket limit for individual coverage and group coverage offered outside the NYSOH that has a calendar plan year.}*

*{Drafting Note: For plans with an out-of-network option, include the first paragraph in G below in this section of the certificate; contract; policy or in the out-of-network rider and insert the second paragraph in G below in this section of the certificate; contract; policy or in the out-of-network rider as applicable. Omit paragraph G in its entirety for plans that do not have out-of-network benefits.}*

[**G.**] [**Your Additional Payments for Out-of-Network Benefits.**

When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits section of this [Certificate; Contract; Policy], You must also pay the amount, if any, by which the Non-Participating Provider’s actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider’s actual charge.

[When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one (1) inclusive payment in that case rather than a separate payment for each billed code. Another example of when We will apply the payment rules to a claim is when You have surgery that involves two (2) surgeons acting as “co-surgeons”. Under the payment rules, the claim from each Provider should have a “modifier” on it that identifies it as coming from a co-surgeon. If We receive a claim that does not have the correct modifier, We will change it and make the appropriate payment. [Additionally, another example of when We will apply a payment rule to a claim is when You receive services from a Health Care Professional who is not a Physician, such as a physician’s assistant. Under the payment rule, the Allowed Amount for a physician’s assistant or other Health Care Professional who is not a Physician will be less than the Allowed Amount for a Physician.]]]

[**H.**] **Allowed Amount.**

“Allowed Amount” means the maximum amount We will pay for the services or supplies Covered under this [Certificate; Contract; Policy], before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

*{Drafting Note: Omit the sentence below for stand-alone out-of-network only coverage and coverage that does not have a provider network.}*

[The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider[, or the amount approved by [XXX]] [, or the Participating Provider’s charge] [, if less].]

*{Drafting Note: The bracketed language is optional.}*

*{Drafting Note: Plans that set different allowed amounts for participating providers inside and outside the service area may insert the bracketed paragraphs below.}*

[The Allowed Amount for Participating Providers will be determined as follows:

**1.** **Participating Facilities in Our Service Area**.

For a participating Facility in Our Service Area, the Allowed Amount will be the amount We have negotiated with the Facility.

**2.** **For All Other** **Participating Providers in Our Service Area**.

For all other Participating Providers in Our Service Area, the Allowed Amount will be] [the amount We have negotiated with the Participating Provider] [, or the Participating Provider’s charge, if less].]

[**3. Participating Facilities Outside Our Service Area.**

For a participating Facility Outside Our Service Area, the Allowed Amount will be the amount We have negotiated with the Facility [or the amount approved by [XXX]].]

[**4.** **For All Other Participating Providers Outside Our Service Area.**

For all other Participating Providers Outside Our Service Area, the Allowed Amount will be the amount We have negotiated with the Participating Provider[, or the amount approved by [XXX]] [, or the Participating Provider’s charge][, if less].]]

*{Drafting Note: The bracketed paragraph is optional.}*

[Our payments to Participating Providers may include financial incentives to help improve the quality [or coordination] of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to You. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.]

*{Drafting Note: Insert the language below regarding the allowed amount for non-participating providers for plans with out-of-network coverage either in this section of the certificate; contract; policy or in the out-of-network rider. Omit references to “non-participating” for coverage that does not have a provider network.}*

[The Allowed Amount for [Non-Participating] Providers will be determined as follows:

*{Drafting Note: Insert the specific reimbursement methodology used for non-participating provider facility charges. Insert the inside our service area bracketed language in the paragraph below if different out-of-network reimbursement methodologies are used inside and outside the service area. Include the type of facility in the first set of brackets if the plan uses different reimbursement methodologies for different types of facilities. If plans use different reimbursement methodologies for different facilities, repeat the section below as appropriate for each facility type.}*

1. [**Facilities** [**in Our Service Area**]**.**

For [insert type of Facility; Facilities] [in Our Service Area], the Allowed Amount will be [the lesser of] [XX% of]

[the Centers for Medicare and Medicaid Services Prospective Payment System (PPS) amount [unadjusted for geographic locality] [for the date(s) on which the services were rendered]. [In the event We are unable to price the services at the PPS rate because of insufficient claims data or there is no PPS rate, the Allowed Amount will be [XX%] of the average amount We have negotiated with Facilities that are Participating Providers of the same or similar type as the non-participating Facility.]]

[the Medicare amount [unadjusted for geographic locality].]

[an amount based on cost information from the Centers for Medicare and Medicaid Services.]

[the FAIR Health rate at the [XX] percentile.]

[the Viant amount.]

[the Facility’s charge.]

[a rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers’ fees and costs to deliver care.]

[an amount based on Our Participating Provider fee schedule or rate.]

[the average amount paid by Us for comparable services to participating Hospitals/Facilities in the same county. If there are no participating Hospitals and/or Facilities in the same county, then the average amount paid by Us for comparable services to participating Hospitals and/or Facilities in the contiguous county or counties.]

[the amount We (or a contractor acting on Our behalf) have negotiated with the Facility.]

*{Drafting Note: Insert the bracketed sentence below if out-of-network benefits are not covered inside the service area. The bracketed language regarding ambulance services may be removed for large group plans only.}*

[The services of Non-Participating Providers inside Our Service Area are not Covered except Emergency Services and Pre-Hospital Emergency Medical Services [and ambulance services] to treat Your Emergency Condition, or unless specifically Covered in this [Certificate; Contract; Policy].]

*{Drafting Note: If an alternative specific reimbursement methodology is used for non-participating provider facility charges, insert the below paragraph, selecting the appropriate reimbursement methodology. If two alternative specific reimbursement methodologies are used, repeat the below paragraph, and for both paragraphs, select the appropriate reimbursement methodology.}*

[If there is no amount as described above, the Allowed Amount will be [the lesser of] [XX% of]

[the Centers for Medicare and Medicaid Services Prospective Payment System (PPS) amount [unadjusted for geographic locality] [for the date(s) on which the services were rendered]. [In the event We are unable to price the services at the PPS rate because of insufficient claims data or there is no PPS rate, the Allowed Amount will be [XX%] of the average amount We have negotiated with Facilities that are Participating Providers of the same or similar type as the non-participating Facility.]]

[the Medicare amount [unadjusted for geographic locality].]

[an amount based on cost information from the Centers for Medicare and Medicaid Services.]

[the Viant amount.]

[a rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers’ fees and costs to deliver care.]

[the Facility’s charge.]

[the FAIR Health rate at the [XX] percentile.]

[an amount based on Our Participating Provider fee schedule or rate.]

[the average amount paid by Us for comparable services to participating Hospitals and/or Facilities in the same county. If there are no participating Hospitals and/or Facilities in the same county, then the average amount paid by Us for comparable services to participating Hospitals and/or Facilities in the contiguous county or counties.]

[the amount We (or a contractor acting on Our behalf) have negotiated with the Facility.]]

*{Drafting Note: The sentences below may be inserted in the certificate; contract; policy or in a separate disclosure statement.}*

[Our Allowed Amount for non-participating Facilities equates to approximately [XX]% of UCR. For this purpose, UCR is the FAIR Health rate at the 80th percentile.]

*{Drafting Note: Insert the specific reimbursement methodology used for non-participating provider facility charges outside the service area if the methodology is different from the reimbursement methodology for non-participating provider facility charges inside the service area. Include the type of facility in the first set of brackets if the plan uses different reimbursement methodologies for different types of facilities. If plans use different reimbursement methodologies for different facilities, repeat the section above as appropriate for each facility type.}*

**[2. Facilities Outside Our Service Area.**

For [insert type of Facility; Facilities] outside Our Service Area, the Allowed Amount will be [the lesser of] [XX% of]

[the Centers for Medicare and Medicaid Services Prospective Payment System amount [unadjusted for geographic locality] [for the date(s) on which the services were rendered]. [In the event We are unable to price the services at the PPS rate because of insufficient claims data or there is no PPS rate, the Allowed Amount will be [XX%] of the average amount We have negotiated with Facilities that are Participating Providers of the same or similar type as the non-participating Facility.]]

[the Medicare amount [unadjusted for geographic locality].]

[an amount based on cost information from the Centers for Medicare and Medicaid Services.]

[the FAIR Health rate at the [XX] percentile.]

[the Viant amount.]

[the Facility’s charge.]

[a rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers’ fees and costs to deliver care.]

[an amount based on Our Participating Provider fee schedule or rate.]

[the average amount paid by Us for comparable services to participating Hospitals and/or Facilities in the same county. If there are no participating Hospitals and/or Facilities in the same county, then the average amount paid by Us for comparable services to participating Hospitals and/or Facilities in the contiguous county or counties.]

[the amount We (or a contractor acting on Our behalf) have negotiated with the Facility.]

*{Drafting Note: If an alternative specific reimbursement methodology used for non-participating provider facility charges is used, insert the below paragraph, selecting the appropriate reimbursement methodology. If two alternative specific reimbursement methodologies are used, repeat the below paragraph, and for both paragraphs, select the appropriate reimbursement methodology.}*

[If there is no amount for Facilities outside Our Service Area as described above, the Allowed Amount will be [the lesser of] [XX% of]­

[the Centers for Medicare and Medicaid Services Prospective Payment System amount [unadjusted for geographic locality] [for the date(s) on which the services were rendered]. [In the event We are unable to price the services at the PPS rate because of insufficient claims data or there is no PPS rate, the Allowed Amount will be [XX%] of the average amount We have negotiated with Facilities that are Participating Providers of the same or similar type as the non-participating Facility.]]

[the Medicare amount [unadjusted for geographic locality].]

[an amount based on cost information from the Centers for Medicare and Medicaid Services.]

[the Viant amount.]

[a rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers’ fees and costs to deliver care.]

[the amount We (or a contractor acting on Our behalf) have negotiated with the Facility.]

[the FAIR Health rate at the [XX] percentile.]

[the Facility’s charge.]

[an amount based on Our Participating Provider fee schedule or rate.]

[the average amount paid by Us for comparable services to participating Hospitals and/or Facilities in the same county. If there are no participating Hospitals and/or Facilities in the same county, then the average amount paid by Us for comparable services to participating Hospitals and/or Facilities in the contiguous county or counties.]]

*{Drafting Note: The sentences below may be inserted in the certificate; contract; policy or in a separate disclosure statement.}*

[Our Allowed Amount for non-participating Facilities outside Our Service Area equates to approximately [XX]% of UCR. For this purpose, UCR is the FAIR Health rate at the 80th percentile.]

*{Drafting Note: Insert the specific reimbursement methodology used for non-participating provider charges. Insert the inside our service area bracketed language in the paragraph below if different out-of-network reimbursement methodologies are used inside and outside the service area.}*

[**3.**] [**For All Other Providers** [**in Our Service Area**]**.**

For all other Providers [in Our Service Area], the Allowed Amount will be [the lesser of] [XX% of]

[the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type [unadjusted for geographic locality].]

[the Medicare amount [unadjusted for geographic locality].]

[an amount based on cost information from the Centers for Medicare and Medicaid Services.]

[the FAIR Health rate at the [XX] percentile.]

[the Viant amount.]

[the Provider’s charge.]

[a rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers’ fees and costs to deliver care.]

[an amount based on Our Participating Provider fee schedule or rate.]

[the average amount paid by Us for comparable services to Participating Providers in the same county. If there are no Participating Providers in the same county, then the average amount paid by Us for comparable services to Participating Providers in the contiguous county or counties.]

*{Drafting Note: Insert the bracketed sentence below if out-of-network benefits are not covered inside the service area. The bracketed language regarding ambulance services may be removed for large group plans only.}*

[The services of Non-Participating Providers inside Our Service Area are not Covered except Emergency Services and Pre-Hospital Emergency Medical Services [and ambulance services] to treat Your Emergency Condition, or unless specifically Covered in this [Certificate; Contract; Policy].]

*{Drafting Note: If an alternative specific reimbursement methodology used for all other providers’ charges is used, insert the below paragraph, selecting the appropriate reimbursement methodology. If two alternative specific reimbursement methodologies are used, repeat the below paragraph, and for both paragraphs, select the appropriate reimbursement methodology.}*

[If there is no amount as described above, the Allowed Amount will be [the lesser of] [XX% of]

[the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type [unadjusted for geographic locality].]

[the Medicare amount [unadjusted for geographic locality].]

[an amount based on cost information from the Centers for Medicare and Medicaid Services.]

[the Viant amount.]

[a rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers’ fees and costs to deliver care.]

[the Provider’s charge.]

[the FAIR Health rate at the [XX] percentile.]

[an amount based on Our Participating Provider fee schedule or rate.]

[the average amount paid by Us for comparable services to Participating Providers in the same county. If there are no Participating Providers in the same county, then the average amount paid by Us for comparable services to Participating Providers in the contiguous county or counties.]]

[For [freestanding] physical therapists [,] [and] [occupational therapists] [,] [and] [speech therapists] [in Our Service Area], the Allowed Amount will be [the lesser of] [XX% of]

[the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type [unadjusted for geographic locality].]

[the published rates allowed by the Centers of Medicare and Medicaid Services for Medicare for the same or similar service.]

[the Medicare amount [unadjusted for geographic locality].]

[the FAIR Health rate at the [XX] percentile.]

[the Viant amount.]

[the Provider’s charge.]

[an amount based on Our Participating Provider fee schedule or rate.]

[the average amount paid by Us for comparable services to Participating Providers in the same county. If there are no Participating Providers in the same county, then the average amount paid by Us for comparable services to Participating Providers in the contiguous county or counties.]]

[For Durable Medical Equipment, a prosthetic device or implant, if there is no code listed or source pricing, the Allowed Amount will be [[1.3] times the manufacturers’ invoice price][[XX]% of the Centers for Medicare and Medicaid Services for the same or similar equipment from a freestanding supplier, or the Centers for Medicare and Medicaid Services competitive bid rates.]

[For [freestanding] laboratory services, the Allowed Amount will be [XX]% of the published rates allowed by the Centers for Medicare and Medicaid Services for the same or similar service.]

*{Drafting Note: The sentences below may be inserted in the certificate; contract; policy or in a separate disclosure statement.}*

[Our Allowed Amount for Non-Participating Providers equates to approximately [XX]% of UCR. For this purpose, UCR is the FAIR Health rate at the 80th percentile.]

*{Drafting Note: Insert the specific reimbursement methodology used for non-participating provider charges outside the service area if the methodology is different from the reimbursement methodology for non-participating provider charges inside the service area.}*

[**4.**] [**For All Other Providers Outside Our Service Area.**

For all other Providers outside Our Service Area, the Allowed Amount will be [the lesser of] [XX% of]

[the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type [unadjusted for geographic locality].]

[the Medicare amount [unadjusted for geographic locality].]

[an amount based on cost information from the Centers for Medicare and Medicaid Services.]

[the FAIR Health rate at the [XX] percentile.]

[the Viant amount.]

[the Provider’s charge.]

[a rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers’ fees and costs to deliver care.]

[an amount based on Our Participating Provider fee schedule or rate.]

[the average amount paid by Us for comparable services to Participating Providers in the same county. If there are no Participating Providers in the same county, then the average amount paid by Us for comparable services to Participating Providers in the contiguous county or counties.]

[the amount We have negotiated with the Provider.]

[the amount approved by [XXX].]

*{Drafting Note: If an alternative specific reimbursement methodology used for all other Providers’ charges is used, insert the below paragraph, selecting the appropriate reimbursement methodology. If two alternative specific reimbursement methodologies are used, repeat the below paragraph, and for both paragraphs, select the appropriate reimbursement methodology.}*

[If there is no amount as described above for all other Providers outside Our Service Area, the Allowed Amount will be [the lesser of] [XX% of]

[the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type [unadjusted for geographic locality].]

[the Medicare amount [unadjusted for geographic locality].]

[an amount based on cost information from the Centers for Medicare and Medicaid Services.]

[the Viant amount.]

[a rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers’ fees and costs to deliver care.]

[the amount We have negotiated with the Provider.]

[the amount approved by [XXX].]

[the Provider’s charge.]

[the FAIR Health rate at the [XX] percentile.]

[an amount based on Our Participating Provider fee schedule or rate.]

[the average amount paid by Us for comparable services to Participating Providers in the same county. If there are no Participating Providers in the same county, then the average amount paid by Us for comparable services to Participating Providers in the contiguous county or counties.]]

[For [freestanding] physical therapists[,] [and] [occupational therapists][,] [and] [speech therapists] outside Our Service Area, the Allowed Amount will be [the lesser of] [xx% of]

[the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type [unadjusted for geographic locality].]

[the Medicare amount [unadjusted for geographic locality].]

[the published rates allowed by the Centers for Medicare and Medicaid Services for Medicare for the same or similar service.]

[the FAIR Health rate at the [XX] percentile.]

[the Viant amount.]

[the Provider’s charge.]

[an amount based on Our Participating Provider fee schedule or rate.]

[the average amount paid by Us for comparable services to Participating Providers in the same county. If there are no Participating Providers in the same county, then the average amount paid by Us for comparable services to Participating Providers in the contiguous county or counties.]]

[For Durable Medical Equipment, a prosthetic device or implant, if there is no code listed or source pricing, the Allowed Amount will be [[1.3] times the manufacturers’ invoice price][[XX]% of the Centers for Medicare and Medicaid Services for the same or similar equipment from a freestanding supplier, or the Centers for Medicare and Medicaid Services competitive bid rates.]

[For [freestanding] laboratory services, the Allowed Amount will be [XX]% of the published rates allowed by the Centers for Medicare and Medicaid Services for the same or similar service.

*{Drafting Note: The sentences below may be inserted in the certificate; contract; policy or in a separate disclosure statement.}*

[Our Allowed Amount for Non-Participating Providers outside Our Service Area equates to approximately [XX]% of UCR. For this purpose, UCR is the FAIR Health rate at the 80th percentile.]

*{Drafting Note: The paragraph below may not be used in the out-of-network make available benefit required pursuant to Insurance Law* *§ 3241(b). Insert the methodologies used within the bracketed language.}*

[**5.**] [**Physician-Administered Pharmaceuticals.**

For Physician-administered pharmaceuticals, We use gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by [RJ Health Systems, Thomson Reuters (published in its Red Book)], or Us based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.]

*{Drafting Note: Insert the paragraph below for plans with out-of-network coverage either in the certificate; contract; policy or in the out-of-network rider. Insert the first bracketed sentence below if the plan does not use UCR for its allowed amount.* *Omit references to “non-participating” for coverage that does not have a provider network.}*

**[Our Allowed Amount is not based on UCR.] The [Non-Participating] Provider’s actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the [Non-Participating] Provider’s charge. Contact Us at [XXX; the number on Your ID card] [or visit Our website [at XXX]] for information on Your financial responsibility when You receive services from a [Non-Participating] Provider.**

[We reserve the right to negotiate a lower rate with Non-Participating Providers [or to pay a [XXX] host plan’s rate, if lower]. [If the Provider participates in a network for an equivalent product offered by a [related; affiliated] insurer or HMO in another state, [and the Provider has agreed to extend the rate to this [Certificate; Contract; Policy],] the rate the Provider has agreed to accept from the other insurer or HMO will apply.] [Medicare based rates referenced in and applied under this section shall be updated no less than annually.]]

*{Drafting Note: Insert the paragraph above as applicable in the certificate; contract; policy or out-of-network rider.}*

*{Drafting Note: All coverage types must insert the last two sentences of this section regarding the allowed amount for emergency services and pre-hospital emergency medical services.}*

See the Emergency Services and Urgent Care section of this [Certificate; Contract; Policy] for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this [Certificate; Contract; Policy] for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.