

Excellus Health Plan, Inc.

Excellus BlueCross BlueShield

Univera Healthcare

EXEC-1, EXER-2; EXEC-2,EXER-2; EXER-1

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Excellus Health Plan, Inc.
 Excellus BlueCross BlueShield
 Univera Healthcare

Effective Date: January 1, 2014
 Community Rated

EXEC-1, EXER-2; EXEC-2, EXER-2; EXER-1
 Preferred Provider Organization Certificate of Coverage

Excellus Health Plan, Inc.
 Excellus BlueCross BlueShield / Univera Healthcare

Effective Date: January 1, 2014
 Community Rated

2014 Individual Premium Rates -Rochester Region

Option	HIOS Plan ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<u>EXEC-1, EXER-2[no Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090004	503.81	1,007.63	856.48	1,435.87	NA
<u>EXEC-1, EXER-2[no Pediatric Dental], EXER-1</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090002	513.39	1,026.78	872.76	1,463.15	NA
<u>EXEC-1, EXER-2[with Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090003	509.66	1,019.33	866.42	1,452.54	NA
<u>EXEC-1, EXER-2[with Pediatric Dental], EXER-1</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090001	519.34	1,038.70	882.88	1,480.14	NA
<u>EXEC-2, EXER-2[no Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	207.57
<u>EXEC-2, EXER-2[with Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	209.98

Excellus Health Plan, Inc.
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 Community Rated

2014 Individual Premium Rates - Syracuse Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<u>EXEC-1, EXER-2[no Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090004	612.60	1,225.20	1,041.42	1,745.91	NA
<u>EXEC-1, EXER-2[no Pediatric Dental], EXER-1</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090002	624.24	1,248.48	1,061.20	1,779.08	NA
<u>EXEC-1, EXER-2[with Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090003	619.72	1,239.42	1,053.51	1,766.18	NA
<u>EXEC-1, EXER-2[with Pediatric Dental], EXER-1</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090001	631.49	1,262.97	1,073.52	1,799.74	NA
<u>EXEC-2, EXER-2[no Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	252.39
<u>EXEC-2, EXER-2[with Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	255.31

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 Preferred Provider Organization Certificate of Coverage

Excellus Health Plan, Inc.
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Effective Date: January 1, 2014
 Community Rated

2014 Individual Premium Rates - Utica/Watertown Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<u>EXEC-1, EXER-2[no Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090004	652.11	1,304.21	1,108.58	1,858.51	NA
<u>EXEC-1, EXER-2[no Pediatric Dental], EXER-1</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090002	664.50	1,328.99	1,129.64	1,893.82	NA
<u>EXEC-1, EXER-2[with Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090003	659.68	1,319.36	1,121.45	1,880.08	NA
<u>EXEC-1, EXER-2[with Pediatric Dental], EXER-1</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090001	672.21	1,344.42	1,142.76	1,915.81	NA
<u>EXEC-2, EXER-2[no Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	268.66
<u>EXEC-2, EXER-2[with Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	271.77

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2014 Individual Premium Rates - Albany Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<u>EXEC-1, EXER-2[no Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090004	652.11	1,304.21	1,108.58	1,858.51	NA
<u>EXEC-1, EXER-2[no Pediatric Dental], EXER-1</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090002	664.50	1,328.99	1,129.64	1,893.82	NA
<u>EXEC-1, EXER-2[with Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090003	659.68	1,319.36	1,121.45	1,880.08	NA
<u>EXEC-1, EXER-2[with Pediatric Dental], EXER-1</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090001	672.21	1,344.42	1,142.76	1,915.81	NA
<u>EXEC-2, EXER-2[no Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	268.66
<u>EXEC-2, EXER-2[with Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	271.77

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EXEC-1, EXER-2; EXEC-2, EXER-2; EXER-1
 Preferred Provider Organization Certificate of Coverage

Excellus Health Plan, Inc.
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 Community Rated

2014 Individual Premium Rates - Mid-Hudson Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<u>EXEC-1, EXER-2[no Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090004	652.11	1,304.21	1,108.58	1,858.51	NA
<u>EXEC-1, EXER-2[no Pediatric Dental], EXER-1</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090002	664.50	1,328.99	1,129.64	1,893.82	NA
<u>EXEC-1, EXER-2[with Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090003	659.68	1,319.36	1,121.45	1,880.08	NA
<u>EXEC-1, EXER-2[with Pediatric Dental], EXER-1</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090001	672.21	1,344.42	1,142.76	1,915.81	NA
<u>EXEC-2, EXER-2[no Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090006	NA	NA	NA	NA	268.66
<u>EXEC-2, EXER-2[with Pediatric Dental]</u> Excellus BCBS Platinum Standard IND PPO	78124NY1090005	NA	NA	NA	NA	271.77

Excellus Health Plan, Inc.
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 Community Rated

2014 Individual Premium Rates - Buffalo Region

Option	HIOS ID	Single	Sub & Spouse	Sub & Child(ren)	Family	Per Child (3x Max)
<u>EXEC-1, EXER-2[no Pediatric Dental]</u> Univera Platinum Standard IND PPO	78124NY1100004	633.60	1,267.18	1,077.10	1,805.74	NA
<u>EXEC-1, EXER-2[no Pediatric Dental], EXER-1</u> Univera Platinum Standard IND PPO	78124NY1100002	645.64	1,291.26	1,097.57	1,840.05	NA
<u>EXEC-1, EXER-2[with Pediatric Dental]</u> Univera Platinum Standard IND PPO	78124NY1100003	640.95	1,281.89	1,089.60	1,826.70	NA
<u>EXEC-1, EXER-2[with Pediatric Dental], EXER-1</u> Univera Platinum Standard IND PPO	78124NY1100001	653.13	1,306.25	1,110.31	1,861.41	NA
<u>EXEC-2, EXER-2[no Pediatric Dental]</u> Univera Platinum Standard IND PPO	78124NY1100006	NA	NA	NA	NA	261.04
<u>EXEC-2, EXER-2[with Pediatric Dental]</u> Univera Platinum Standard IND PPO	78124NY1100005	NA	NA	NA	NA	264.06

Outline of Benefits

EXEC-1, EXER-2; EXEC-1, EXER-2

COST-SHARING	Participating Member Responsibility for Cost- Sharing	Non-Participating Member Responsibility for Cost-Sharing	
Deductible <ul style="list-style-type: none"> • Individual • Family Out-of-Pocket Limit <ul style="list-style-type: none"> • Individual • Family 	None None \$2,000 \$4,000	\$1,000 \$2,000 \$3,000 \$5,000 Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of- Pocket Limit. You must pay the amount by which the Non-Participating Provider's charge exceeds Our Allowed Amount.	
OFFICE VISITS	Participating Member Responsibility for Cost- Sharing	Non-Participating Member Responsibility for Cost- Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$15 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Specialist Office Visits (or Home Visits)	\$35 Copayment	20% Coinsurance after Deductible	See Benefit For Description
PREVENTIVE CARE	Participating Member Responsibility for Cost- Sharing	Non-Participating Member Responsibility for Cost- Sharing	Limits
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* • Adult Annual Physical Examinations* • Adult Immunizations* • Routine Gynecological Services/Well Woman Exams* • Mammography Screenings* • Sterilization Procedures for Women* • Vasectomy • Bone Density Testing* • Screening for Prostate Cancer 	Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full \$15 PCP, \$35 Specialist Copayment Covered in full \$15 PCP, \$35 Specialist Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
<ul style="list-style-type: none"> • All other preventive services required by USPSTF and HRSA. • *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. 	Covered in full Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	20% Coinsurance after Deductible Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
EMERGENCY CARE	Participating Member Responsibility for Cost- Sharing	Non-Participating Member Responsibility for Cost- Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$100 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services	\$100 Copayment	20% Coinsurance after Deductible	See Benefit For Description

Emergency Department Copayment/Coinsurance waived if Hospital admission.	\$100 Copayment	\$100 Copayment	See Benefit For Description
Urgent Care Center	\$55 Copayment	20% Coinsurance after Deductible	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Member Responsibility for Cost- Sharing	Non-Participating Member Responsibility for Cost- Sharing	Limits
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or	\$35 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Office Setting • Performed as Outpatient Hospital Services	\$35 Copayment	20% Coinsurance after Deductible	
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
Ambulatory Surgical Center Facility Fee	\$100 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Anesthesia Services (all settings)	Covered in full	20% Coinsurance after Deductible	See Benefit For Description
Autologous Blood Banking	10% Coinsurance	20% Coinsurance after Deductible	See Benefits For Description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	\$15 Copayment \$15 Copayment Included As Part of Inpatient Hospital Service Cost-Sharing	20% Coinsurance after Deductible 20% Coinsurance after Deductible Included As Part of Inpatient Hospital Service Cost-Sharing	See Benefits For Description
Chemotherapy • Performed in a PCP Office	\$15 Copayment	20% Coinsurance after Deductible	See Benefit For Description
• Performed in a Specialist Office • Performed as Outpatient Hospital Services	\$15 Copayment \$15 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible	
Chiropractic Services	\$35 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	\$15 Copayment \$35 Copayment \$35 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting	\$15 Copayment \$15 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
• Performed as Outpatient Hospital Services	\$15 Copayment	20% Coinsurance after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$25 Copayment	20% Coinsurance after Deductible	60 visits per condition, per lifetime combined therapies
Home Health Care	\$15 Copayment	20% Coinsurance after Deductible	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description

Infusion Therapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy 	\$15 Copayment \$15 Copayment \$15 Copayment \$15 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	\$0 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Laboratory Procedures			See Benefit For Description
<ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Laboratory Facility or Specialist Office Performed as Outpatient Hospital Services 	\$15 Copayment \$35 Copayment \$35 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	
Maternity & Newborn Care <ul style="list-style-type: none"> Prenatal Care Inpatient Hospital Services and Birthing Center Physician and Nurse Midwife Services for Delivery Breast Pump 	Covered In Full \$500 Copayment per admission \$100 Copayment per admission Covered in Full	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	\$ 100 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Preadmission Testing	\$0 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Diagnostic Radiology Services <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services 	\$15 Copayment \$35 Copayment \$35 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Therapeutic Radiology Services <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services 	\$15 Copayment \$15 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$25 Copayment	20% Coinsurance after Deductible	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$35 Copayment	20% Coinsurance after Deductible Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist when a Referral is obtained.	See Benefit For Description

Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery 	\$100 Copayment \$100 Copayment \$100 Copayment \$15 PCP, \$35 Specialist Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See Benefit For Description All Transplants Must be Performed at Designated Facilities
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Member Responsibility for Cost- Sharing	Non-Participating Member Responsibility for Cost- Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	\$15 Copayment	20% Coinsurance after Deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	\$15 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-Day Supply) 	\$15 Copayment	20% Coinsurance after Deductible	See Benefit For Description
• Diabetic Education	\$15 Copayment	20% Coinsurance after Deductible	
Durable Medical Equipment & Braces	10% Coinsurance	20% Coinsurance after Deductible	See Benefit For Description
External Hearing Aids	10% Coinsurance	20% Coinsurance after Deductible	Single Purchase Once Every 3 Years
Cochlear Implants	10% Coinsurance	20% Coinsurance after Deductible	One Per Ear Per Time Covered
Hospice Care <ul style="list-style-type: none"> • Inpatient • Outpatient 	\$500 Copayment per admission \$15 Copayment	20% Coinsurance per admission after Deductible 20% Coinsurance after Deductible	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	10% Coinsurance	20% Coinsurance after Deductible	See Benefit For Description
Prosthetic Devices <ul style="list-style-type: none"> • External • Internal 	10% Coinsurance \$0 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	Participating Member Responsibility for Cost- Sharing	Non-Participating Member Responsibility for Cost- Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	\$500 Copayment per admission	20% Coinsurance per admission after Deductible	See Benefit For Description
Observation Stay	\$100 Copayment	20% Coinsurance after Deductible	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	\$500 Copayment per admission	20% Coinsurance per admission after Deductible	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	\$500 Copayment per admission	20% Coinsurance per admission after Deductible	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Participating Member Responsibility for Cost- Sharing	Non-Participating Member Responsibility for Cost- Sharing	Limits

Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	\$500 Copayment per admission	10% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	\$15 Copayment	10% Coinsurance after Deductible	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	\$500 Copayment per admission	10% Coinsurance per admission after Deductible	See Benefit For Description
Outpatient Substance Use Services	\$15 Copayment	10% Coinsurance after Deductible	Unlimited; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30 Day Supply Tier 1 Tier 2 Tier 3	\$10 Copayment \$30 Copayment \$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	\$25 Copayment \$75 Copayment \$150 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
WELLNESS BENEFITS	Participating Member Responsibility for Cost- Sharing	Non-Participating Member Responsibility for Cost- Sharing	
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse
PEDIATRIC [DENTAL & VISION CARE]	Participating Member Responsibility for Cost- Sharing	Non-Participating Member Responsibility for Cost- Sharing	Limits
[Pediatric Dental Care] • [Preventive/Routine Dental Care] • [Major Dental (Endodontics & Prosthodontics)] • [Orthodontia]	[\$15 Copayment] [\$15 Copayment] [\$15 Copayment]	[20% Coinsurance after Deductible] [20% Coinsurance after Deductible] [20% Coinsurance after Deductible]	[One Dental Exam & Cleaning Per 6-Month Period]
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	\$15 Copayment 10% Coinsurance 10% Coinsurance	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12- Month Period

EXER-1 : RIDER TO EXTEND COVERAGE FOR YOUNG ADULTS THROUGH AGE 29

This rider which has been selected by the [Subscriber; Group] extends the eligibility of Children for coverage under Your [Contract; Certificate] and any applicable rider(s) thereto. All of the terms, conditions and limitations of the [Contract; Certificate] to which this rider is attached also apply to this Rider, except where they are specifically changed by this rider.

1. Young Adults Covered through Age 29. If You selected Parent and Child /Children or Family coverage, Your young adult Child will be eligible for coverage through the age of 29 years when the young adult:

- A. Is unmarried;
- B. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
- C. Lives, works or resides in New York State or Our Service Area.

The young adult need not live with or be financially dependent upon You or be a student in order to be covered under this rider.

The young adult's children are not eligible for coverage under this rider.