**[SECTION [XXXI]]**

*{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents if a section number is used for riders. This rider is to be used for out-of-network coverage if the out-of-network coverage is not described in the base certificate; contract; policy.}*

**Out-of-Network Benefits Rider**

This rider amends Your [Certificate; Contract; Policy] to provide benefits for Covered Services that are received from Non-Participating Providers and have not been approved by Us to be covered on an in-network basis. These benefits are referred to as “out-of-network benefits” and are subject to greater Copayment, Deductible and Coinsurance amounts than the benefits available if You obtain the same services from Participating Providers.

**A. Out-of-Network Benefits.**

Benefits under this rider are only available for Medically Necessary services provided by Non-Participating Providers [outside Our Service Area] which would have been Covered under Your [Certificate; Contract; Policy] if they had been provided by a Participating Provider. [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 the [Certificate; Contract; Policy].] All services must be furnished by Providers appropriately licensed to provide the particular service being rendered. [Some services are only Covered when you go to a Participating Provider.] See the Schedule of Benefits section of this [Certificate; Contract; Policy] for a list of the services Covered out-of-network.

*{Drafting Note: The bracketed language regarding ambulance services may be removed for large group plans only.}*

**B. Day and Limit Visitations.**

In any case where benefits of the [Certificate; Contract; Policy] are limited to a certain number of days or visits, such limits shall apply [in the aggregate; separately] to services provided pursuant to the [Certificate; Contract; Policy] and this rider. Any days or visits covered pursuant to this rider will reduce the number of days or visits available under the [Certificate; Contract; Policy] and vice versa.

*{Drafting Note: The paragraph below is optional and may be included in the certificate; contract; policy or in this rider.}*

**C.** [**Out-of-Network Services Subject to Preauthorization.**

Our Preauthorization is required before You receive certain Covered out-of-network Services. See the Schedule of Benefits section of this [Certificate; Contract; Policy] for the services that require Preauthorization.]

*{Drafting Note: The provisions below are optional and may be included in the certificate; contract; policy or in this rider.­}*

[**D.**][**Preauthorization Procedure.**

If You seek coverage for services that require Preauthorization, You must call Us [or Our vendor] at [XXX; the number on Your ID card].

You must contact Us to request Preauthorization as follows:

* [At least [two (2) weeks] prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.]

*{Drafting Note: Use two weeks or less than two weeks.}*

* [At least [two (2) weeks] prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.]

*{Drafting Note: Use two weeks or less than two weeks.}*

* [Within the first [three (3)] months of a pregnancy, or as soon as reasonably possible and again within [48] hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.]

*{Drafting Note: Use three months or longer than three months. Use 48 hours or longer than 48 hours.}*

* [Before air ambulance services are rendered for a non-Emergency Condition.]

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.]

*{Drafting Note: The paragraph below is optional and may be included in the certificate; contract; policy or in this rider.}*

[**E.**][**Failure to Seek Preauthorization.**

If You fail to seek Our Preauthorization for benefits subject to this section, We will pay an amount $[500] less than We would otherwise have paid for the care, or We will pay only [50]% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining [charges; cost for services]. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.]

*{Drafting Note: The paragraph below may be included in the certificate; contract; policy or in this rider, as applicable.}*

[**F.**] [**Out-of-Network Deductible.**

This [Certificate; Contract; Policy] has a separate Out-of-Network Deductible in the Schedule of Benefits section of this [Certificate; Contract; Policy] that You must pay for Covered out-of-network Services during each Plan Year before We provide coverage for out-of-network services. [If You have other than individual coverage, the individual Out-of-Network Deductible applies to each person covered under this [Certificate; Contract; Policy].] However, after Out-of-Network Deductible payments for persons covered under this [Certificate; Contract; Policy] collectively total the family Out-of-Network Deductible amount in the Schedule of Benefits section of this [Certificate; Contract; Policy]in a Plan Year, no further Out-of-Network Deductible will be required for any person covered under this [Certificate; Contract; Policy] for that Plan Year. [Cost-Sharing for in-network services does 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 Out-of-Network Deductible.** [The Out-of-Network Deductible runs from January 1 to December 31 of each calendar year.]]

*{Drafting Note: Insert the bracketed sentence beginning with “If you have other than individual coverage” as applicable. Insert the bracketed sentence beginning “Cost-Sharing for in-network services” as applicable. Insert the last sentence regarding the January 1 calendar year deductible 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 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 the certificate; contract; policy or in this rider.}*

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

[This [Certificate; Contract; Policy] does not have 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 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 penalty described in [this rider; 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 “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 the non-standard NYSOH plan 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.}*

[**H.**] **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.]]

*{Drafting Note: Insert the paragraph above as applicable.}*

[**I.**] **Allowed Amount.**

“Allowed Amount” means the maximum amount we will pay for the services or supplies covered under this rider, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount for Non-Participating Providers 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 like kind 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 your service area if the methodology is different from the reimbursement methodology for non-participating provider charges inside your 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 published rates allowed by the Centers for 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 Medicaire 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; contact; policy or in this 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: The paragraph above must be included in the certificate; contract; policy or in this rider.}*

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.

[**J.**] **Filing a Claim for Out-of-Network Benefits.**

A claim must be filed with Us by You or the out-of-network Provider. Claims forms can be obtained from Us by calling [XXX; the number on your ID card] [or by visiting Our website [at XXX]].

[**K.**] **Exclusions.**

Except as expressly modified by this rider, all of the exclusions of the [Certificate; Contract; Policy] apply to the benefits covered by this rider. In addition, none of the following services are covered under this rider:

[insert services not covered on an out-of-network basis]

*{Drafting Note: If out-of-network coverage is offered, all state mandated benefits (other than benefits that are solely essential health benefits) must be covered out-of-network.}*

[**L.**] **Controlling** [**Certificate;** **Contract; Policy**]**.**

All of the terms, conditions, limitations, and exclusions of Your [Certificate; Contract; Policy] to which this rider is attached shall also apply to this rider except where specifically changed by this rider.