

ESSENTIAL PLAN SECTION [XXVI]

{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents if a section number is used for the Schedule of Benefits.}

[insert health plan name] SCHEDULE OF BENEFITS

***See Benefit Description in [Contract; Policy] for More Details**

Non-Participating Provider services are not Covered for any services other than those related to emergency care and You pay the full cost for services performed by a non-participating provider except in cases related to emergency care.

COST-SHARING	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Deductible <ul style="list-style-type: none">Individual	\$0	\$0	\$0	\$0
Out-of-Pocket Limit <ul style="list-style-type: none">Individual <p>[Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a Plan Year basis.]</p>	\$2,000	\$200	\$200 For covered prescription drugs, the Maximum Out-of-Pocket Limit is \$50 per calendar quarter.	\$0
OFFICE VISITS				
Primary Care Office Visits (or Home Visits)	\$15 [in Office] [by Telehealth]	\$0 [in Office] [by Telehealth]	\$0 [in Office] [by Telehealth]	\$0 [in Office] [by Telehealth]
Specialist Office Visits (or Home Visits)	\$25	\$0	\$0	\$0

[[Preauthorization; Referral] required]	[in Office] [by Telehealth] [[Preauthorization; Referral] required]	[in Office] [by Telehealth] [[Preauthorization; Referral] required]	[in Office] [by Telehealth] [[Preauthorization; Referral] required]	[in Office] [by Telehealth] [[Preauthorization; Referral] required]
PREVENTIVE CARE				
<ul style="list-style-type: none"> Adult Annual Physical Examinations* Adult Immunizations* Routine Gynecological Services/Well Woman Exams* Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer Sterilization Procedures for Women* Vasectomy 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>See Surgical Services Section</p> <p>[Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services;</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>See Surgical Services Section</p> <p>[Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services;</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>See Surgical Services Section</p> <p>[Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services;</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>See Surgical Services Section</p> <p>[Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services;</p>

<ul style="list-style-type: none"> Bone Density Testing* Screening for Prostate Cancer 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 	Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]
	Covered in full	Covered in full	Covered in full	Covered in full
	Covered in full	Covered in full	Covered in full	Covered in full
	Covered in full	Covered in full	Covered in full	Covered in full
[Referral required]	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) [Referral required]	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) [Referral required]	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) [Referral required]	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) [Referral required]
EMERGENCY CARE				
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$75	\$0	\$0	\$0

Non-Emergency Ambulance Services [[Preauthorization; Referral] required]	\$75 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 See [Contract; Policy] on how to use this service	\$0 See [Contract; Policy] on how to use this service
Emergency Department Copayment waived if admitted to Hospital	\$75 Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Copayment	\$0	\$0	\$0
Urgent Care Center [Preauthorization required for out-of-network Urgent Care; Referral required]	\$25 [in Office] [by Telehealth] [Preauthorization required for out-of-network Urgent Care; Referral required]	\$0 [in Office] [by Telehealth] [Preauthorization required for out-of-network Urgent Care; Referral required]	\$0 [in Office] [by Telehealth] [Preauthorization required for out-of-network Urgent Care; Referral required]	\$0 [in Office] [by Telehealth] [Preauthorization required for out-of-network Urgent Care; Referral required]
PROFESSIONAL SERVICES and OUTPATIENT CARE				
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	\$25	\$0	\$0	\$0

<ul style="list-style-type: none"> Performed in a Specialist Office 	\$25	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
<p>Allergy Testing and Treatment</p> <ul style="list-style-type: none"> Performed in a PCP Office 	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
<p>Ambulatory Surgical Center Facility Fee</p>	\$50	\$0	\$0	\$0
[[Preauthorization; Referral] required]				
Anesthesia Services (all settings)	Covered in full	Covered in full	Covered in full	Covered in full
[[Preauthorization;	[[Preauthorization;	[[Preauthorization;	[[Preauthorization;	[[Preauthorization;

Referral] required]	Referral] required]	Referral] required]	Referral] required]	Referral] required]
Cardiac and Pulmonary Rehabilitation <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services [[Preauthorization; Referral] required]	\$25 \$25 Included as part of inpatient Hospital service cost-sharing [[Preauthorization; Referral] required]	\$0 \$0 Included as part of inpatient Hospital service cost-sharing [[Preauthorization; Referral] required]	\$0 \$0 Included as part of inpatient Hospital service cost-sharing [[Preauthorization; Referral] required]	\$0 \$0 Included as part of inpatient Hospital service cost-sharing [[Preauthorization; Referral] required]
Chemotherapy and Immunotherapy <ul style="list-style-type: none"> [Administration] <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services [Performed at Home] 	\$15 \$15 \$15 \$15 \$15	\$0 \$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0 \$0

<ul style="list-style-type: none"> [Chemotherapy and Immunotherapy Medications] <p>[[Preauthorization; Referral] required]</p>	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Chiropractic Services	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Diagnostic Testing				
<ul style="list-style-type: none"> Performed in a PCP Office 	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$25	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Dialysis				
<ul style="list-style-type: none"> Performed in a PCP Office 				

<ul style="list-style-type: none"> Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services [Performed at Home] <p>[Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year. See benefit description for more information.]</p> <p>[[Preauthorization; Referral] required]</p>	\$15	\$0	\$0	\$0
	\$15	\$0	\$0	\$0
	\$15	\$0	\$0	\$0
	\$15 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$15</p> <p>60 visits per condition, per Plan Year combined therapies</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$0</p> <p>60 visits per condition, per Plan Year combined therapies</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$0</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$0</p> <p>[[Preauthorization; Referral] required]</p>
<p>Home Health Care</p> <p>40 visits Per Plan Year</p>	\$15	\$0	\$0	\$0

Referral] required]				
Inpatient Medical Visits	\$0 per admission	\$0 per admission	\$0 per admission	\$0 per admission
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Interruption of Pregnancy				
<ul style="list-style-type: none"> Medically Necessary Abortions (Unlimited) 	Covered in Full	Covered in Full	Covered in Full	Covered in Full
<ul style="list-style-type: none"> Elective Abortions (One (1) procedure per Plan Year) 	See Surgical Services Cost-Sharing	\$0	\$0	\$0
Laboratory Procedures				
<ul style="list-style-type: none"> Performed in a PCP Office 	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$25	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed in a Freestanding Laboratory Facility or Specialist Office 	\$25	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed as Outpatient Hospital 	\$25	\$0	\$0	\$0

Services	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Maternity and Newborn Care				
• Prenatal Care	\$0	\$0	\$0	\$0
• Inpatient Hospital Services [and Birthing Center]	\$150 per admission	\$0	\$0	\$0
One (1)] home care visit[s] is Covered at no Cost-Sharing if mother is discharged from Hospital early				
• Physician and Midwife Services for Delivery	\$50	\$0	\$0	\$0
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	\$0	\$0	\$0	\$0
Covered for duration of breast feeding				
• Postnatal Care	<u>Included in Physician and Midwife Services for Delivery Cost-</u>	<u>Included in Physician and Midwife Services for Delivery Cost-Sharing</u>	<u>Included in Physician and Midwife Services for Delivery Cost-Sharing</u>	<u>Included in Physician and Midwife Services for Delivery Cost-Sharing</u>

	<u>Sharing</u>			
[Preauthorization required] [for inpatient services; breast pump]	[Preauthorization required] [for inpatient services; breast pump]	[Preauthorization required] [for inpatient services; breast pump]	[Preauthorization required] [for inpatient services; breast pump]	[Preauthorization required] [for inpatient services; breast pump]
Outpatient Hospital Surgery Facility Charge	\$50	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Preadmission Testing	\$0	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Prescription Drugs Administered in Office [or Outpatient Facilities]				
• [Administration]				
• Performed in a PCP Office	\$15	\$0	\$0	\$0
• Performed in Specialist Office	\$25	\$0	\$0	\$0
• [Performed in Outpatient Facilities]	\$25	\$0	\$0	\$0
• [Prescription Drug Cost-Sharing]	\$15	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Diagnostic Radiology				

Services				
• Performed in a PCP Office	\$15	\$0	\$0	\$0
• Performed in a Specialist Office	\$25	\$0	\$0	\$0
• Performed in a Freestanding Radiology Facility	\$25	\$0	\$0	\$0
• Performed as Outpatient Hospital Services	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Therapeutic Radiology Services				
• Performed in a Specialist Office	\$15	\$0	\$0	\$0
• Performed in a Freestanding Radiology Facility	\$15	\$0	\$0	\$0
• Performed as Outpatient Hospital Services	\$15	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Rehabilitation Services (Physical Therapy,				

Occupational Therapy or Speech Therapy)				
<ul style="list-style-type: none"> • [Performed in a PCP Office] • [Performed in a Specialist Office] • [Performed in an Outpatient Facility] 	\$15	\$0	\$0	\$0
[[Preauthorization; Referral] required]	\$15	\$0	\$0	\$0
	\$15	\$0	\$0	\$0
	60 visits per condition, per Plan Year combined therapies	60 visits per condition, per Plan Year combined therapies	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
	Speech and physical therapy are only Covered following a Hospital stay or surgery	Speech and physical therapy are only Covered following a Hospital stay or surgery		
	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]		
[Retail Health Clinic Care]	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Second Opinions on the	\$25	\$0	\$0	\$0

Diagnosis of Cancer, Surgery and Other				
[[Preauthorization; Referral] required]]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants</p> <p>All transplants must be performed at designated [Center of Excellence] Facilities</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery 	<p>\$50</p> <p>\$50</p> <p>\$50</p> <p>\$15 (when performed at PCP office)</p> <p>\$25 (when performed at specialist office)</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>

[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
[Telemedicine Program]	\$ 15 PCP visit \$ 25 specialist visit	\$0	\$0	\$0
ADDITIONAL SERVICES, EQUIPMENT and DEVICES				
Diabetic Equipment, Supplies and Self- Management Education				
• Diabetic Equipment, Supplies and Insulin (30-day; Up to a 90 supply)	\$15	\$0	\$0	\$0
• Diabetic Education	\$15	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Durable Medical Equipment and Braces	5% cost-sharing	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
External Hearing Aids	5% cost-sharing	\$0	\$0	\$0
(Single purchase one every three (3) years				
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Cochlear Implants	5% cost-sharing	\$0	\$0	\$0

(One (1) per ear per time Covered)				
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Hospice Care				
• Inpatient	\$150	\$0	\$0	\$0
• Outpatient	\$15	\$0	\$0	\$0
210 days per Plan Year				
Five (5) visits for family bereavement counseling				
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Medical Supplies	5% coinsurance	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Prosthetic Devices				
• External	5% coinsurance	\$0	\$0	\$0
One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements				

<ul style="list-style-type: none"> Internal 	Included as part of Inpatient Hospital Cost-sharing	Included as part of Inpatient Hospital Cost-sharing	Included as part of Inpatient Hospital Cost-sharing	Included as part of Inpatient Hospital Cost-sharing
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
INPATIENT SERVICES and FACILITIES				
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	\$150	\$0	\$0	\$0
[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]	[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]	[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]	[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]	[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]
Autologous Blood Banking Services	5% co-insurance	\$0	\$0	\$0
[[Preauthorization; Referral] required [in outpatient settings]]	[[Preauthorization; Referral] required [in outpatient settings]]	[[Preauthorization; Referral] required [in outpatient settings]]	[[Preauthorization; Referral] required [in outpatient settings]]	[[Preauthorization; Referral] required [in outpatient settings]]

Observation Stay Copay waived if direct transfer from outpatient surgery setting to observation	\$75	\$0	\$0	\$0
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) 200 days per Plan Year Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility	\$150	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) [[Preauthorization; Referral] required]	\$150 [60 days per Plan Year combined therapies] [[Preauthorization; Referral] required]	\$0 [60 days per Plan Year combined therapies] [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	\$150	\$0	\$0	\$0

60 per Plan Year combined therapies				
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES				
<p>Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p>[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]</p>	<p>\$150</p> <p>[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]</p>	<p>\$0</p> <p>[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]</p>	<p>\$0</p> <p>[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]</p>	<p>\$0</p> <p>[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]</p>
<p>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</p> <ul style="list-style-type: none"> [Office Visits] 	<p>\$15</p> <p>[in Office] [by Telehealth]</p>	<p>\$0</p> <p>[in Office] [by Telehealth]</p> <p>\$0</p>	<p>\$0</p> <p>[in Office] [by Telehealth]</p>	<p>\$0</p> <p>[in Office] [by Telehealth]</p>
<ul style="list-style-type: none"> [All Other Outpatient] 	<p>\$15</p>	<p>[in Office] [by Telehealth]</p>	<p>\$0</p>	<p>\$0</p>

Services]	[in Office] [by Telehealth]	[[Preauthorization; Referral] required]	[in Office] [by Telehealth]	[in Office] [by Telehealth]
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]		[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
ABA Treatment for Autism Spectrum Disorder	[Covered in full] [\$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [in Office] [by Telehealth]	[Covered in full] [\$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [in Office] [by Telehealth]	[\$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [in Office] [by Telehealth] [Non-Participating Provider services are not Covered and You pay the full cost]	
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	
Assistive Communication Devices for Autism Spectrum Disorder	[Covered in full] [\$ Copayment] [% Coinsurance] [[after; not subject to] Deductible]	[Covered in full] [\$ Copayment] [% Coinsurance] [[after; not subject to] Deductible]	[\$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [Non-Participating Provider services are not Covered and You pay the full cost]	
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	\$150	\$0	\$0	\$0
[[Preauthorization; Referral] required. However,				

Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.]	[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.]	[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.]	[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.]	[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.]
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) [[Preauthorization; Referral] required]	\$15 [in Office] [by Telehealth] [[Preauthorization; Referral] required]	\$0 [in Office] [by Telehealth] [[Preauthorization; Referral] required]	\$0 [in Office] [by Telehealth] [[Preauthorization; Referral] required]	\$0 [in Office] [by Telehealth] [[Preauthorization; Referral] required]
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF [and obtained at a participating pharmacy].				
Retail Pharmacy				

30-day supply				
Tier 1	\$6	\$1	\$1	\$0
Tier 2	\$15	\$3	\$3	\$0
Tier 3	\$30	\$3	\$3	\$0
Preauthorization is not required for a covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.				
[Up to a 90-day supply for Maintenance Drugs]				[\$0]
[Tier 1	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	
	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	
Tier 2	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$0]
Tier 3]				[\$0]
[Mail Order Pharmacy]				

[Up to a 30-day supply Tier 1 Tier 2 Tier 3]				
	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$0]
	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	
	[\$ Copayment]	[\$ Copayment]	[\$ Copayment] [[\$0]
[Up to a 90-day supply Tier 1 Tier 2 Tier 3]				
	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$0]
	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	
	[\$ Copayment]	[\$ Copayment]	[\$ Copayment] [[\$0]
Enteral Formulas [Tier 1 Tier 2				
	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$0]
	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	
	[\$ Copayment]	[\$ Copayment]]	[\$ Copayment]	[\$0]

Tier 3]				[\$0]
NON-PRESCRIPTION DRUGS (only include for EP 3 &4)			\$.50	\$0
WELLNESS BENEFITS				
[Gym Reimbursement]	[Up to \$200 per six (6)-month period]	[Up to \$200 per six (6)-month period]	[Up to \$200 per six (6)-month period]	[Up to \$200 per six (6)-month period]
[DENTAL and VISION CARE]				
[Dental Care]				
<ul style="list-style-type: none"> Preventive Dental Care 	\$0	\$0	\$0	\$0
<ul style="list-style-type: none"> Routine Dental Care 	\$0	\$0	\$0	\$0
<ul style="list-style-type: none"> Major Dental (Oral Surgery, Endodontics, Periodontics and Prosthodontics) 	\$0	\$0	\$0	\$0
One (1) dental exam and cleaning per six (6)-month period.				

<p>Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) to 12-month intervals</p> <p>[Orthodontics and major dental require [Preauthorization; Referral]]</p>	<p>[Orthodontics and major dental require [Preauthorization; Referral]]</p>	<p>[Orthodontics and major dental require [Preauthorization; Referral]]</p>	<p>[Orthodontics and major dental require [Preauthorization; Referral]]</p>	<p>[Orthodontics and major dental require [Preauthorization; Referral]]</p>
<p>[Vision Care]</p> <ul style="list-style-type: none"> Exams Lenses and Frames Contact Lenses <p>One (1) exam per [12-month period; Plan Year; calendar year], unless otherwise medically necessary</p> <p>One (1) prescribed lenses and frames per [12-month period; [Plan Year; calendar year], unless otherwise medically necessary</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>[Contact lenses require [Preauthorization; Referral]]</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>[Contact lenses require [Preauthorization; Referral]]</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>[Contact lenses require [Preauthorization; Referral]]</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>[Contact lenses require [Preauthorization; Referral]]</p>

<p>[Contact lenses require [Preauthorization; Referral]]</p>				
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[All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the [Certificate; Contract; Policy], You will be responsible for the full cost of the services.]

{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage. Only include preauthorization language if applicable. If plans only require preauthorization for certain services or items (e.g., specific DME items), they must list those specific services or items in the schedule.}

{Drafting note: Include the following EP 1 & 2 [Eligible American Indians/Alaska Natives, as determined by NYSOH, are exempt from Cost Sharing requirements, including when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through a Referral under the Purchased/Referred Care (PRC) program, formerly known as the Contract Health Services (CHS).]}

{Drafting Notes:

- 1. Under state law and the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements (deductibles, copayments, coinsurance, and out-of-pocket expenses) and treatment limitations applicable to the mental health or substance use disorder benefits must be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan. Further, if the health plan provides coverage for out-of-network services, then it also must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorders consistent with the MHPAEA.*
- 2. Cost-sharing for services delivered using telehealth shall be at least as favorable to the insured as cost-sharing for the same service when not delivered via telehealth, pursuant to Insurance Law §§ 3217-h(a), 4306-g(a), and Public Health Law § 4406-g(1).*
- 3. Plans have the flexibility to decide when a referral is required on a gated product.*
- 4. The cost-sharing for emergency services in a hospital must be the same for in-network and out-of-network services.*
- 5.. The cost-sharing for ABA treatment and assistive communication devices must be the PCP copayment.*
- 6.. The cost-sharing for diabetic equipment, supplies, and self-management education must be the PCP copayment.*

7.. Medically necessary abortions may not be subject to a copayment or coinsurance and may only be subject to a deductible in a high deductible health plan.}

8.. Effective June 1, 2021 there shall be no cost-sharing obligations for enrollees for covered dental and vision services.