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 • Individual	$0	$0	$0	$0
Out-of-Pocket Limit • Individual [Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a Plan Year basis.]	$2,000	$200	$200	$0
OFFICE VISITS				
Primary Care Office Visits (or Home Visits)	$15	$0	$0	$0
Specialist Office Visits (or Home Visits) **[[Preauthorization; Referral] required]**	$25 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**

PREVENTIVE CARE				
• Adult Annual Physical Examinations*	Covered in full	Covered in full	Covered in full	Covered in full
• Adult Immunizations*	Covered in full	Covered in full	Covered in full	Covered in full
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	Covered in full	Covered in full
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Covered in full	Covered in full	Covered in full
	Covered in full	Covered in full	Covered in full	Covered in full
• Sterilization Procedures for Women*	See Surgical Services Section	See Surgical Services Section	See Surgical Services Section	See Surgical Services Section
• Vasectomy	Covered in full	Covered in full	Covered in full	Covered in full
• Bone Density Testing*				
• Screening for Prostate Cancer	$15	$0	$0	$0
• Performed in PCP Office	$25	$0	$0	$0

• Performed in Specialist Office • 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 **[Referral required]**	Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)] **[Referral required]**	Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) **[Referral required]**	Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) **[Referral required]**	Covered in full 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 /	$75	$0	$0	$0

Coinsurance waived if Hospital admission]				
Urgent Care Center **[Preauthorization required for out-of-network Urgent Care; Referral required]**	$25 **[Preauthorization required for out-of-network Urgent Care; Referral required]**	$0 **[Preauthorization required for out-of-network Urgent Care; Referral required]**	$0 **[Preauthorization required for out-of-network Urgent Care; Referral required]**	$0 **[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 • Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	$25 $25 **[[Preauthorization; Referral] required]**	$0 $0 **[[Preauthorization; Referral] required]**	$0 $0 **[[Preauthorization; Referral] required]**	$0 $0 **[[Preauthorization; Referral] required]**
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	$15 $25	$0 $0	$0 $0	$0 $0

[[Preauthorization; Referral] required]	**[[Preauthorization; Referral] required]**	**[[Preauthorization; Referral] required]**	**[[Preauthorization; Referral] required]**	**[[Preauthorization; Referral] required]**
Ambulatory Surgical Center Facility Fee **[[Preauthorization; Referral] required]**	$50	$0	$0	$0
Anesthesia Services (all settings) **[[Preauthorization; Referral] required]**	Covered in full **[[Preauthorization; Referral] required]**	Covered in full **[[Preauthorization; Referral] required]**	Covered in full **[[Preauthorization; Referral] required]**	Covered in full **[[Preauthorization; Referral] required]**
Autologous Blood Banking **[[Preauthorization; Referral] required]**	5% coinsurance **[[Preauthorization; Referral] required]**	Covered in full **[[Preauthorization; Referral] required]**	Covered in full **[[Preauthorization; Referral] required]**	Covered in full **[[Preauthorization; Referral] required]**
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office	$25	$0	$0	$0
• Performed as Outpatient Hospital Services	$25	$0	$0	$0
• Performed as Inpatient Hospital Services **[[Preauthorization; Referral] required]**	Included as part of inpatient Hospital service cost-sharing **[[Preauthorization; Referral] required]**	Included as part of inpatient Hospital service cost-sharing **[[Preauthorization; Referral] required]**	Included as part of inpatient Hospital service cost-sharing **[[Preauthorization; Referral] required]**	Included as part of inpatient Hospital service cost-sharing **[[Preauthorization; Referral] required]**
Chemotherapy • Performed in a PCP Office	$15	$0	$0	$0

• Performed in a Specialist Office	$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]**
Chiropractic Services **[[Preauthorization; Referral] required]**	$25 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
Clinical Trials **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service **[[Preauthorization; Referral] required]**
Diagnostic Testing				
• Performed in a PCP Office	$15	$0	$0	$0
• Performed in a Specialist Office	$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]**
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	$15 $15 $15 **[[Preauthorization; Referral] required]**	$0 $0 $0 **[[Preauthorization; Referral] required]**	$0 $0 $0 **[[Preauthorization; Referral] required]**	$0 $0 $0 **[[Preauthorization; Referral] required]**
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **[[Preauthorization; Referral] required]**	$15 60 visits per condition, per Plan Year combined therapies **[[Preauthorization; Referral] required]**	$0 60 visits per condition, per Plan Year combined therapies **[[Preauthorization; Referral] required]**	$0 20 visits per therapy per Plan Year **[[Preauthorization; Referral] required]**	$0 20 visits per therapy per Plan Year **[[Preauthorization; Referral] required]**
Home Health Care 40 visits Per Plan Year	$15 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	

[[Preauthorization; Referral] required]				
Infertility Services **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **[[Preauthorization; Referral] required]**
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy (Home infusion counts toward home health care visit limits) **[[Preauthorization; Referral] required]**	 $15 $15 $15 $15 **[[Preauthorization; Referral] required]**	 $0 $0 $0 $0 **[[Preauthorization; Referral] required]**	 $0 $0 $0 $0 **[[Preauthorization; Referral] required]**	 $0 $0 $0 $0 **[[Preauthorization; Referral] required]**

Inpatient Medical Visits **[[Preauthorization; Referral] required]**	$0 per admission **[[Preauthorization; Referral] required]**	$0 per admission **[[Preauthorization; Referral] required]**	$0 per admission **[[Preauthorization; Referral] required]**	$0 per admission **[[Preauthorization; Referral] required]**
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	 $15 $25 $25 **[[Preauthorization; Referral] required]**	 $0 $0 $0 **[[Preauthorization; Referral] required]**	 $0 $0 $0 **[[Preauthorization; Referral] required]**	 $0 $0 $0 **[[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
• Physician and Midwife Services for Delivery	$50	$0	$0	$0
• Breast Pump	$0	$0	$0	$0
• Postnatal Care	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing
[Preauthorization	**[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]**

required] [for inpatient services; breast pump]				
Outpatient Hospital Surgery Facility Charge **[[Preauthorization; Referral] required]**	$50 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
Preadmission Testing **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	 $15 $25 $25 **[[Preauthorization; Referral] required]**	 $0 $0 $0 **[[Preauthorization; Referral] required]**	 $0 $0 $0 **[[Preauthorization; Referral] required]**	 $0 $0 $0 **[[Preauthorization; Referral] required]**
Therapeutic Radiology Services • Performed in a Freestanding	 $15	 $0	 $0	 $0

Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	$15 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **[[Preauthorization; Referral] required]**	$15 60 visits per condition, per Plan Year combined therapies **[[Preauthorization; Referral] required]**	$0 60 visits per condition, per Plan Year combined therapies **[[Preauthorization; Referral] required]**	$0 20 visits per therapy per Plan Year **[[Preauthorization; Referral] required]**	$0 20 visits per therapy per Plan Year **[[Preauthorization; Referral] required]**
Second Opinions on the Diagnosis of Cancer, Surgery and Other **[[Preauthorization; Referral] required]]**	$25 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)				

All transplants must be performed at designated Facilities • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery **[[Preauthorization; Referral] required]**	$50 $50 $50 $15 (when performed at PCP office) $25 (when performed at specialist office **[[Preauthorization; Referral] required]**	$0 $0 $0 $0 **[[Preauthorization; Referral] required]**	$0 $0 $0 $0 **[[Preauthorization; Referral] required]**	$0 $0 $0 $0 **[[Preauthorization; Referral] required]**
[Telemedicine Program]	$ 15 PCP visit $ 25 specialist visit	$0	$0	$0
ADDITIONAL SERVICES, EQUIPMENT and DEVICES				
ABA Treatment for Autism Spectrum Disorder **[[Preauthorization; Referral] required]**	$15 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
Assistive Communication Devices for Autism	$15	$0	$0	$0

Spectrum Disorder **[[Preauthorization; Referral] required]**	**[[Preauthorization; Referral] required]**	**[[Preauthorization; Referral] required]**	**[[Preauthorization; Referral] required]**	**[[Preauthorization; Referral] required]**
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education **[[Preauthorization; Referral] required]**	$15 $15 **[[Preauthorization; Referral] required]**	$0 $0 **[[Preauthorization; Referral] required]**	$0 $0 **[[Preauthorization; Referral] required]**	$0 $0 **[[Preauthorization; Referral] required]**
Durable Medical Equipment and Braces **[[Preauthorization; Referral] required]**	5% cost-sharing **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
External Hearing Aids **(Single purchase one every three (3) years)s** **[[Preauthorization; Referral] required]**	5% cost-sharing **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**

Cochlear Implants **(One (1) per ear per time Covered)** **[[Preauthorization; Referral] required]**	5% cost-sharing **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
Hospice Care • Inpatient • Outpatient 210 days per Plan Year Five (5) visits for family bereavement counseling **[[Preauthorization; Referral] required]**	 $150 $15 **[[Preauthorization; Referral] required]**	 $0 $0 **[[Preauthorization; Referral] required]**	 $0 $0 **[[Preauthorization; Referral] required]**	 $0 $0 **[[Preauthorization; Referral] required]**
Medical Supplies **[[Preauthorization; Referral] required]**	5% coinsurance **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
Prosthetic Devices • External One (1) prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the	 5% coinsurance	 $0	 $0	 $0

prosthetic devices and its parts • Internal **[[Preauthorization; Referral] required]**	Included as part of Inpatient Hospital Cost-sharing **[[Preauthorization; Referral] required]**	Included as part of Inpatient Hospital Cost-sharing **[[Preauthorization; Referral] required]**	Included as part of Inpatient Hospital Cost-sharing **[[Preauthorization; Referral] required]**	Included as part of Inpatient Hospital Cost-sharing **[[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) **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]**	$150 **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]**	$0 **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]**	$0 **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]**	$0 **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]]**
Observation Stay Copay waived if direct transfer from outpatient surgery setting to observation	$75	$0	$0	$0
Skilled Nursing Facility	$150	$0	$0	$0

(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 **[[Preauthorization; Referral] required]**	**[[Preauthorization; Referral] required]**	**[[Preauthorization; Referral] required]**	**[[Preauthorization; Referral] required]**	**[[Preauthorization; Referral] required]**
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) [60 days per Plan Year combined therapies] **[[Preauthorization; Referral] required]**	$150 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) 60 per Plan Year combined **[[Preauthorization; Referral] required]**	$150 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES				
Inpatient Mental Health	$150	$0	$0	$0

Care (for a continuous confinement when in a Hospital) **[[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.]]**
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) **[[Preauthorization; Referral] required]**	$15 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency**	$150 **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency**	$0 **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or for**	$0 **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]**	$0 **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency**

admissions or for Participating OASAS-certified Facilities.]	**admissions or for Participating OASAS-certified Facilities.]**	**Participating OASAS-certified Facilities.]**		**admissions.]**
Outpatient Substance Use Services Up to 20 visits per Plan Year may be used for family counseling **[[Preauthorization; Referral] required]**	$15 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[Preauthorization; Referral] required]**	$0 **[[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 Tier 2	 $6 $15	 $1 $3	 $1 $3	 $0 $0

Tier 3	$30	$3	$3	$0
[Up to a 90-day supply for Maintenance Drugs] [Tier 1 Tier 2 Tier 3]	 [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible]	 [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible]	 [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ 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]	[See benefit for description]
[Mail Order Pharmacy]				
[Up to a 90-day supply Tier 1 Tier 2 Tier 3]	 [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment]	 [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment]	 [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment]	[See benefit for description]

	[% Coinsurance] [[after; not subject to] Deductible]	[% Coinsurance] [[after; not subject to] Deductible]	[% Coinsurance] [[after; not subject to] Deductible] [Non-Participating Provider services are not Covered and You pay the full cost]	
Enteral Formulas [Tier 1 Tier 2 Tier 3]	 [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible]	 [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible]	 [$ Copayment] [% Coinsurance] [[after; not subject to] Deductible] [$ 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]	See benefit for description
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]				

• Preventive Dental Care	$15	$0	$0	$0
• Routine Dental Care	$15	$0	$0	$0
• Major Dental (Endodontics, Periodontics and Prosthodontics	$15	$0	$0	$0
One (1) dental exam and cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) to 12-month intervals **[Orthodontics and major dental require [Preauthorization; Referral]]**	**[Orthodontics and major dental require [Preauthorization; Referral]]**	**[Orthodontics and major dental require [Preauthorization; Referral]]**	**[Orthodontics and major dental require [Preauthorization; Referral]]**	**[Orthodontics and major dental require [Preauthorization; Referral]]**
[Vision Care] • Exams	$15	$0	$0	$0

• Lenses and Frames • Contact Lenses One (1) exam per [12-month period; Plan Year] One (1) prescribed lenses and frames per Plan Year **[Contact lenses require [Preauthorization; Referral]]**	10% coinsurance 10% coinsurance **[Contact lenses require [Preauthorization; Referral]]**	$0 $0 **[Contact lenses require [Preauthorization; Referral]]**	$0 $0 **[Contact lenses require [Preauthorization; Referral]]**	$0 $0 **[Contact lenses require [Preauthorization; Referral]]**

[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 Notes:
1. Any cost-sharing or preauthorization requirements for mental health and substance use disorder services must be consistent with other comparable medical benefits.

2. Plans have the flexibility to decide when a referral is required on a gated product.

3. The cost-sharing for emergency services in a hospital must be the same for in-network and out-of-network services.

4. The cost-sharing for ABA treatment and assistive communication devices must be the PCP copayment.

5. The cost-sharing for diabetic equipment, supplies, and self-management education must be the PCP copayment }