{Drafting Note: This cover page is required for the Essential Plan.}

This is Your

ESSENTIAL PLAN
[CONTRACT; POLICY]

Issued by

[insert health plan name]

[This is Your individual [Contract; Policy] for the Essential Plan coverage issued by [insert health plan name.] This [Contract; Policy], together with the attached Schedule of Benefits, applications and any amendment or rider amending the terms of this [Contract; Policy], constitute the entire agreement between You and Us.

You have the right to return this [Contract; Policy]. Examine it carefully. If You are not satisfied, You may return this [Contract; Policy] to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this [Contract; Policy].

Renewability. The renewal date for this [Contract; Policy] is twelve months from the effective date of coverage. This [Contract; Policy] will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this [Contract; Policy] or by You upon 30 days' prior written notice to Us.

In-Network Benefits. This [Contract; Policy] only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers [in Our [XXX] Network] [or Our affiliate's [XXX] Network] [and Participating Pharmacies in Our [XXX] Network] [who are located within Our Service Area]. [Care Covered under this [Contract; Policy] (including Hospitalization) must be provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us. In order to receive the benefits under this [Contract; Policy], You must contact Your Primary Care Physician before You obtain the services, except for services to treat an Emergency [or urgent] Condition described in the Emergency Services and Urgent Care section of this [Contract; Policy].] Except for care for an Emergency [or urgent] Condition described in the Emergency Services and Urgent Care section of this [Contract; Policy], You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.]
{Drafting Note: The bracketed primary care physician language may be included for EPO or HMO coverage.}

READ THIS ENTIRE [CONTRACT; POLICY] CAREFULLY. [IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP [CONTRACT; POLICY].] IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS [CONTRACT; POLICY].

This [Contract; Policy] is governed by the laws of New York State.

[Insert signature, name and title of company officer(s).]

{Drafting Note: The sentence below is optional.}
If You need foreign language assistance to understand this [Contract; Policy], You may call Us at [XXX; the number on Your ID card].