

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, or other services specified in this Schedule of Benefits or Model Language; You may pay the full cost for other services performed by a non-participating provider.

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
COST-SHARING Deductible <ul style="list-style-type: none">Individual Out-of-Pocket Limit <ul style="list-style-type: none">Individual [Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a Plan Year basis.]	\$0 \$2000	\$0 \$360	\$0 \$200	\$0 \$200 For covered prescription drugs, the Maximum Out- of-Pocket Limit is \$50 per calendar quarter.	\$0 \$0
OFFICE VISITS * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008					

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
(MHPAEA).					
Primary Care Office Visits (or Home Visits)	\$15 [in Office] [by Telehealth]	\$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	\$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]	[in Office] [by Telehealth] [[Preauthorization; Referral] required]
PREVENTIVE CARE * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost- Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).					
<ul style="list-style-type: none"> Adult Annual Physical Examinations* Adult Immunizations* Routine Gynecological Services/Well Woman Exams* 	<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>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>Covered in full</p> <p>Covered in full</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Sterilization Procedures for Women* 	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
<ul style="list-style-type: none"> Vasectomy 	See Surgical Services Section	See Surgical Services Section	See Surgical Services Section	See Surgical Services Section	See Surgical Services Section
	[Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]	[Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]	[Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]	[Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]	[Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]
<ul style="list-style-type: none"> Bone Density Testing* 	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
<ul style="list-style-type: none"> Screening for Prostate Cancer 	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
<ul style="list-style-type: none"> Screening for Colon Cancer 	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
<ul style="list-style-type: none"> All other preventive services required by USPSTF and HRSA 	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
<ul style="list-style-type: none"> *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA 	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
[Referral required]	[Referral required]	[Referral required]	[Referral required]	[Referral required]	[Referral required]
EMERGENCY CARE * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).					
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$75	\$75	\$0	\$0	\$0
Non-Emergency Ambulance Services [[Preauthorization; Referral] required]	\$75 [[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

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
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	\$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]	\$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 * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).					
Advanced Imaging Services Performed in a Freestanding		\$25	\$0	\$0	\$0

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Radiology Facility or Office Setting	\$25				
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$25	\$25	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$25	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Allergy Testing and Treatment					
<ul style="list-style-type: none"> Performed in a PCP Office 	\$15	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$25	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Ambulatory Surgical Center Facility Fee	\$50	\$50	\$0	\$0	\$0
[[Preauthorization; Referral] required]					
Anesthesia Services (all settings)	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
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 	\$25 \$25 Included as part of inpatient Hospital service cost-sharing [[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]
[[Preauthorization; Referral] required]					

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
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] • [Chemotherapy and Immunotherapy Medications] 	\$15 \$15 [\$ Copayment] [% Coinsurance] [[after; not subject to] Deductible]	\$15 \$15 [\$ Copayment] [% Coinsurance] [[after; not subject to] Deductible]	\$0 \$0 [\$ Copayment] [% Coinsurance] [[after; not subject to] Deductible]	\$0 \$0 [\$ Copayment] [% Coinsurance] [[after; not subject to] Deductible]	\$0 \$0 [\$ Copayment] [% Coinsurance] [[after; not subject to] Deductible]
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Chiropractic Services	\$25	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[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	Use Cost-Sharing for appropriate service

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Diagnostic Testing					
• Performed in a PCP Office	\$15	\$15	\$0	\$0	\$0
• Performed in a Specialist Office	\$25	\$25	\$0	\$0	\$0
• Performed as Outpatient Hospital Services	\$25	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
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 	\$15	\$15	\$0	\$0	\$0
	\$15	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$15	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> [Performed at Home] 					
[Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year. See benefit description for more information.]	\$15	\$15	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) [[Preauthorization; Referral] required]	\$15 60 visits per condition, per Plan Year combined therapies [The visit limit does not apply to Habilitation Services for a mental health condition or substance use disorder.] [[Preauthorization; Referral] required]	\$15 60 visits per condition, per Plan Year combined therapies [The visit limit does not apply to Habilitation Services for a mental health condition or substance use disorder.] [[Preauthorization; Referral] required]	\$0 60 visits per condition, per Plan Year combined therapies [The visit limit does not apply to Habilitation Services for a mental health condition or substance use disorder.] [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]
Home Health Care 40 visits Per Plan Year [The visit limit does not apply to Home Health Care for a mental health condition or substance use disorder.]	\$15	\$15	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[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)	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]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
			[[Preauthorization; Referral] required]		
Infusion Therapy <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 • Home Infusion Therapy • [Infusion Therapy Medication] (Home infusion counts toward home health care visit limits) [[Preauthorization; Referral] required]	\$15 \$15 \$15 \$15 \$15	\$15 \$15 \$15 \$15 \$15	\$0 \$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0 \$0
	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Inpatient Medical Visits	\$0 per admission	\$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]	[[Preauthorization; Referral] required]
Interruption of Pregnancy					
<ul style="list-style-type: none">• Abortion Services•	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Laboratory Procedures <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed in a Freestanding Laboratory Facility or Specialist Office Performed as Outpatient Hospital Services 	\$15 \$25 \$25 \$25	\$15 \$25 \$25 \$25	\$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> Prenatal Care Inpatient Hospital Services [and Birthing Center] 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 Breastfeeding Support, Counseling and Supplies, Including Breast Pumps Covered for duration of breast feeding Postnatal Care 	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>[Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p> <p>[Covered in full] [\$ Copayment] [% Coinsurance] [per admission]</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>[Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p> <p>[Covered in full]</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>[Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>[Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>[Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p> <p>[Covered in full]</p>

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
	[[after; not subject to] Deductible]	[\$ Copayment] [% Coinsurance] [per admission] [[after; not subject to] Deductible]	[Covered in full] [\$ Copayment] [% Coinsurance] [per admission] [[after; not subject to] Deductible]	[Covered in full] [\$ Copayment] [% Coinsurance] [per admission] [[after; not subject to] Deductible]	[\$ Copayment] [% Coinsurance] [per admission] [[after; not subject to] Deductible]
[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]	[Preauthorization required] [for inpatient services; breast pump]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Outpatient Hospital Surgery Facility Charge	\$50	\$50	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Preadmission Testing	\$0	\$0	\$0	\$0	\$0
[[Preauthorization; Referral] required]	[[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	\$15	\$0	\$0	\$0
• Performed in Specialist Office	\$25	\$25	\$0	\$0	\$0
• [Performed in Outpatient Facilities]	\$25	\$25	\$0	\$0	\$0
• [Prescription Drug Cost-Sharing]	\$15	\$15	\$0	\$0	\$0
See note 6 below on page 31 regarding Cost-Sharing for Covered Prescription Drugs for the treatment of diabetes.					
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Diagnostic Radiology					

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Services <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services [[Preauthorization; Referral] required]	\$15 \$25 \$25 \$25 [[Preauthorization; Referral] required]	\$15 \$25 \$25 \$25 [[Preauthorization; Referral] required]	\$0 \$0 \$0 \$0 [[Preauthorization; Referral] required]	\$0 \$0 \$0 \$0 [[Preauthorization; Referral] required]	\$0 \$0 \$0 \$0 [[Preauthorization; Referral] required]
Therapeutic Radiology Services <ul style="list-style-type: none"> Performed in a Specialist Office Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services [[Preauthorization; Referral] required]	\$15 \$15 \$15 [[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]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
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 \$15 \$15	\$15 \$15 \$15	\$0 \$0 \$0	\$0 \$0 \$0	\$0 \$0 \$0
[[Preauthorization; Referral] required]	60 visits per condition, per Plan Year combined therapies [The visit limit does not apply to Rehabilitation Services for a mental health condition or substance use disorder.] Speech and physical therapy are only Covered following a Hospital stay or surgery [[Preauthorization; Referral] required]	60 visits per condition, per Plan Year combined therapies [The visit limit does not apply to Rehabilitation Services for a mental health condition or substance use disorder.] Speech and physical therapy are only Covered following a Hospital stay or surgery [[Preauthorization; Referral] required]	60 visits per condition, per Plan Year combined therapies [The visit limit does not apply to Rehabilitation Services for a mental health condition or substance use disorder.] Speech and physical therapy are only Covered following a Hospital stay or surgery [[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
[Retail Health Clinic Care]	\$25	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
Second Opinions on the Diagnosis of Cancer, Surgery and Other	\$25	\$25	\$0	\$0	\$0
[[Preauthorization; Referral] required]]	[[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 [Centers of Excellence; Hospitals]</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</p>	<p>\$50</p> <p>\$50</p> <p>\$50</p> <p>\$15 (when performed at PCP office)</p> <p>\$25 (when performed at</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>

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
[[Preauthorization; Referral] required]	specialist office) [[Preauthorization; Referral] required]	specialist office) [[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
[Telemedicine Program]	\$ 15 PCP visit \$ 25 specialist visit	\$ 15 PCP visit \$ 25 specialist visit	\$0	\$0	\$0
ADDITIONAL BENEFITS, EQUIPMENT and DEVICES * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).					
Diabetic Equipment, Supplies and Self-Management Education Diabetes Initiative - Upon federal approval, starting in 2025 to make services more accessible and affordable, NY State of Health will cover the in-network cost-sharing such as copayments, and coinsurance for Essential Plan enrollees who have a primary diagnosis of diabetes. See note 6 below on page 31.		\$15	\$0	\$0	\$0

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
<ul style="list-style-type: none"> Diabetic Education **See note 6 below on page 31. [[Preauthorization; Referral] required]	\$15** [[Preauthorization; Referral] required]	\$15 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]
Durable Medical Equipment and Braces [[Preauthorization; Referral] required]	5% cost-sharing [[Preauthorization; Referral] required]	5% cost-sharing [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]
External Hearing Aids <ul style="list-style-type: none"> Prescription Hearing Aids (Single purchase one every three (3) years)	5% cost-sharing [[Preauthorization; Referral] required]	5% cost-sharing [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]
<ul style="list-style-type: none"> [Over the Counter Hearing Aids] (Single purchase one every three (3) years)	5% cost-sharing	5% cost-sharing	\$0	\$0	\$0

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Cochlear Implants (One (1) per ear per time Covered) [[Preauthorization; Referral] required]	5% cost-sharing [[Preauthorization; Referral] required]	5% cost-sharing [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]
Hospice Care <ul style="list-style-type: none"> Inpatient Outpatient 210 days per Plan Year Five (5) visits for family bereavement counseling [[Preauthorization; Referral] required]	\$150 \$15 [[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]	5% coinsurance [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]	\$0 [[Preauthorization; Referral] required]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Prosthetic Devices <ul style="list-style-type: none"> External One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements	5% coinsurance	5% coinsurance	\$0	\$0	\$0
<ul style="list-style-type: none"> 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]	Included as part of Inpatient Hospital Cost- sharing [[Preauthorization; Referral] required]
INPATIENT SERVICES * Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).					

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
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.]]	\$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.]]
Autologous Blood Banking Services [[Preauthorization; Referral] required [in outpatient settings]]	5% co-insurance [[Preauthorization; Referral] required [in outpatient settings]]	5% co-insurance [[Preauthorization; Referral] required [in outpatient settings]]	\$0 [[Preauthorization; Referral] required [in outpatient settings]]	\$0 [[Preauthorization; Referral] required [in outpatient settings]]	\$0 [[Preauthorization; Referral] required [in outpatient settings]]
Observation Stay Copay waived if direct transfer from outpatient surgery setting to observation	\$75	\$75	\$0	\$0	\$0

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
<p>Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)</p> <p>200 days per Plan Year [The visit limit does not apply to Skilled Nursing Facility for a mental health condition or substance use disorder.]</p> <p>Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$150</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$150</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$0</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$0</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$0</p> <p>[[Preauthorization; Referral] required]</p>
<p>Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$150</p> <p>[60 days per Plan Year combined therapies] [The visit limit does not apply to Inpatient Habilitation Services for a mental health condition or substance use disorder.]</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$150</p> <p>[60 days per Plan Year combined therapies] [The visit limit does not apply to Inpatient Habilitation Services for a mental health condition or substance use disorder.]</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$0</p> <p>[60 days per Plan Year combined therapies] [The visit limit does not apply to Inpatient Habilitation Services for a mental health condition or substance use disorder.]</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$0</p> <p>[[Preauthorization; Referral] required]</p>	<p>\$0</p> <p>[[Preauthorization; Referral] required]</p>
<p>Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)</p> <p>60 per Plan Year combined therapies [The visit limit does not apply to Inpatient Rehabilitation Services]</p>	<p>\$150</p>	<p>\$150</p>	<p>\$0</p>	<p>\$0</p>	<p>\$0</p>

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
for a mental health condition or substance use disorder.]					
[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES					
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) [[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions.]	\$150 [[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.]]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) <ul style="list-style-type: none"> • Office Visits • [All Other Outpatient Services] • [Opioid Treatment Programs] • [All Other Outpatient Services] 	\$15 [in Office] [by Telehealth] [\$0 Copayment] [in Office] [by Telehealth]	\$15 [in Office] [by Telehealth] [\$0 Copayment] [in Office] [by Telehealth]	\$0 [in Office] [by Telehealth] [\$0 Copayment] [in Office] [by Telehealth]	\$0 [in Office] [by Telehealth] [\$0 Copayment] [in Office] [by Telehealth]	\$0 [in Office] [by Telehealth] [\$0 Copayment] [in Office] [by Telehealth]
[[Preauthorization; Referral] required] However, Preauthorization is not required for Participating OASAS-certified Facilities	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[Preauthorization; Referral] required]	[[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]. See note 6 below on page 31 regarding Cost-Sharing for Covered Prescription Drugs for the treatment of					

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
<p>diabetes.</p> <p>* Cost-Sharing for Covered Services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).</p>					
<p>Retail Pharmacy</p> <p>30-day supply Tier 1</p> <p>Tier 2</p> <p>Tier 3</p> <p>Preauthorization is not required for covered antiretroviral Prescription Drugs for the treatment or prevention of HIV or AIDS and Prescription Drugs used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or</p>	<p>\$6</p> <p>\$15</p> <p>\$30</p> <p>[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].</p>	<p>\$6</p> <p>\$15</p> <p>\$30</p> <p>[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].</p>	<p>\$1</p> <p>\$3</p> <p>\$3</p> <p>[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].</p>	<p>\$1</p> <p>\$3</p> <p>\$3</p> <p>[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].</p>

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
stabilization and for opioid overdose reversal.					
[Up to a 90-day supply for Maintenance Drugs]					
Tier 1	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$0]
Tier 2	[\$ Copayment] [\$ Copayment]				
Tier 3]	[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments;	[\$ Copayment] [\$ Copayment]	[\$ Copayment] \$ Copayment]	[\$ Copayment] [\$ Copayment]	[\$0]
					[Cost-Sharing for

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
	Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].	[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].	[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].	[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].	epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].
[Mail Order Pharmacy] [Up to a 30-day supply Tier 1 Tier 2 Tier 3] The mail order pharmacy Cost-Sharing will apply to Prescription Drugs obtained at a retail Participating Pharmacy that agrees to the same reimbursement amount as the mail order pharmacy.	[\$ Copayment] [\$ Copayment] [\$ Copayment] [Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].	[\$ Copayment] [\$ Copayment] [\$ Copayment] [Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed	[\$ Copayment] [\$ Copayment] [\$ Copayment] [Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar]	[\$ Copayment] [\$ Copayment] [\$ Copayment] [Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year	[\$0] [\$0] [\$0] [Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
		\$100 per [Plan; Calendar] Year after Deductible].	Year after Deductible].	after Deductible].	Deductible].
Up to a 90-day supply Tier 1	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$0]
Tier 2	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$0]
Tier 3]	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$0]
The mail order pharmacy Cost-Sharing will apply to Prescription Drugs obtained at a retail Participating Pharmacy that agrees to the same reimbursement amount as the mail order pharmacy.	[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].	[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].	[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].	[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].	[Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year; [Copayments; Coinsurance] for epinephrine auto-injector devices shall not exceed \$100 per [Plan; Calendar] Year after Deductible].

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Enteral Formulas					
[Tier 1	[\$Copayment]	[\$ Copayment]	[\$ Copayment]	[\$ Copayment]	[\$0]
Tier 2	[\$ Copayment] [\$ Copayment]	[\$ Copayment] [\$	[\$ Copayment]	[\$ Copayment]	[\$0]
Tier 3		Copayment]	[\$ Copayment]	[\$ Copayment]	[\$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]	[Up to \$200 per six (6)-month period]
[DENTAL and VISION CARE]					
[Dental Care]					

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
<ul style="list-style-type: none"> Preventive Dental Care 	\$0	\$0	\$0	\$0	\$0
<ul style="list-style-type: none"> Routine Dental Care 	\$0	\$0	\$0	\$0	\$0
<ul style="list-style-type: none"> Major Dental (Oral Surgery, Endodontics, Periodontics and Prosthodontics) 	\$0	\$0	\$0	\$0	\$0
ne (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]]	[Orthodontics and major dental require [Preauthorization; Referral]]

	[ESSENTIAL PLAN 200 – 250 *]	[ESSENTIAL PLAN 1]	[ESSENTIAL PLAN 2]	[ESSENTIAL PLAN 3]	[ESSENTIAL PLAN 4]
Vision Care] <ul style="list-style-type: none">ExamsLenses and FramesContact 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>[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>\$0</p> <p>\$0</p> <p>\$0</p> <p>[Contact lenses require [Preauthorization; Referral]]</p>	

[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).]}

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 Covered Services with a primary diagnosis of mental health or substance use disorder.

{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. Plans may include the variable "The visit limit does not apply..." as an optional provision to ensure MHPAEA compliance for treatment limitations. 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. Upon federal approval, starting in 2025, for Essential Plan enrollees who have a primary diagnosis of diabetes, NY State of Health will cover the in-network cost-sharing such as copayments and coinsurance for certain items and services related to the diagnosis. Additional information regarding the 2025 Diabetes Initiative can be found here - <https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20U%20-%20Revised%20071124%202025%20Cost%20Sharing%20Reduction%20Initiatives.pdf>*
- 7. Abortion services may not be subject to a copayment or coinsurance.*
- 8. Effective June 1, 2021, there shall be no cost-sharing obligations for enrollees for covered dental and vision services.*
- 9. *Effective April 1, 2024, there shall be no cost-sharing obligations for enrollees who become pregnant while having coverage in any Essential Plan. Cost sharing would be*

waived for the duration of the pregnancy, along with one year of postpartum coverage. The 12-month postpartum coverage period will start on the last day of Your pregnancy and end on the last day of the 12th month.

10. *Insurance Law §§ 3216(i)(31-b), 3221(l)(7-b), and 4303(l-2) provide that every policy that provides coverage for treatment at an opioid treatment program shall not impose a copayment or coinsurance during the course of treatment on an insured for such treatment. "Opioid treatment program" means a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication.*
11. *Insurance Law §§ 3216(i)(39), 3221(k)(23), and 4303(vv) provide that cost-sharing for epinephrine auto-injector devices may not be subject to more than \$100 in cost-sharing annually.*