*{Drafting Note: Use for child only coverage.}*

This is Your

**[PREFERRED PROVIDER ORGANIZATION;**

**EXCLUSIVE PROVIDER ORGANIZATION;**

**HEALTH MAINTENANCE ORGANIZATION;**

**INDEMNITY;**

**POINT OF SERVICE;**

**INSURANCE]**

**[CONTRACT; POLICY]**

Issued by

**[insert health plan name]**

This is Your individual direct payment [Contract; Policy] for [preferred provider organization; health maintenance organization; exclusive provider organization; point-of-service; insurance] coverage issued by [insert health plan name.] This [Contract; Policy], together with the attached Schedule of Benefits, applications and any amendments or riders amending the terms of this [Contract; Policy], constitute the entire agreement between the Responsible Adult or You and Us.

You or the Responsible Adult have the right to return this [Contract; Policy]. Examine it carefully. If You or the Responsible Adult are not satisfied, You or the Responsible Adult may return this [Contract; Policy] to Us and ask Us to cancel it. Your or the Responsible Adult’s request must be made in writing within ten (10) days from the date You or the Responsible Adult receive this [Contract; Policy]. We will refund any Premium paid including any [Contract; Policy] fees or other charges.

**Renewability.** The renewal date for this [Contract; Policy] is January 1 of each year. 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 the Subscriber upon 30 days’ prior written notice to Us. Coverage under this [Contract; Policy] lasts until the end of the year in which You turn 21 years of age.

***{Drafting Note: Use Option 1 below for POS or PPO coverage; Use Option 2 below for EPO, HMO, POS or PPO coverage with a preferred / 2 tiered network; Use Option 3 below for EPO or traditional HMO coverage; Use Option 4 for stand-alone out-of-network only coverage issued with a network product; Omit all options for coverage that does not have a provider network. The standard NYSOH plan may not include a tiered network.}***

***{Drafting Note: Option 1 – Use the two paragraphs below for POS or PPO coverage.}***

[This [Contract; Policy] offers You the option to receive Covered Services on two (2) benefit levels:

**1. In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by 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]. You should always consider receiving health care services first through the in-network benefits portion of this [Contract; Policy]. [In-network 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 in-network benefits, 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].]

*{Drafting Note: The bracketed PCP language may be used for POS or PPO coverage if the plan requires a PCP referral for in-network services.}*

**2.****Out-of-Network Benefits.** The out-of-network benefits portion of this [Contract; Policy] provides coverage when You receive Covered Services from Non-Participating Providers [or when You receive Covered Services from Participating Providers without care being provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us]. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider’s charge. [The services of Non-Participating Providers inside Our Service Area are not Covered except Emergency Services and Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition, or unless specifically Covered in this [ Contract; Policy].] [Some Covered Services, such as [insert benefit example], are only Covered when received from Participating Providers and are not Covered as out-of-network benefits. See the Schedule of Benefits section of this [Contract; Policy] for more information.]]

*{Drafting Note: The bracketed PCP language may be used for POS or PPO coverage if the plan requires a PCP referral for in-network services. Insert the last three bracketed sentences if applicable. If the bracketed sentence limiting out-of-network coverage to outside the service area is inserted, the same sentence must also be inserted in paragraph H of the How Your Coverage Works section.}*

***{Drafting Note: Option 2 – Use the two paragraphs below for EPO, HMO, POS or PPO coverage with a preferred / 2 tiered network.}***

[This [Contract; Policy] offers You the option to receive Covered Services on [two; three] benefit levels:

**1.** **In-Network Preferred Benefits.** In-network preferred benefits are the [highest; higher] level of coverage available. In-network preferred benefits apply when Your care is provided by Preferred Providers [in Our [XXX] Network]. [In-network preferred benefits are only available for [pharmacy] services.] You should always consider receiving health services first through Our Preferred Providers [in Our [XXX] Network].

**2.** **In-Network Benefits.** In-network benefits are the [intermediate; lower] level of coverage available [for [pharmacy] services and the [only; highest] level of benefits available for [medical] services]. In-network benefits apply when Your care is provided by Participating Providers [that are not Preferred Providers] [and are in Our [XXX] Network] [or Our affiliate’s [XXX] Network] [and Participating Pharmacies in Our [XXX] Network] [who are located within Our Service Area]. You should always consider receiving [health care; pharmacy] services first through Preferred Providers and then from Participating Providers that are not Preferred Providers. [In-network care [and in-network preferred 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 in-network benefits, 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].]

*{Drafting Note:* *The bracketed PCP language may be used for EPO, HMO, POS or PPO coverage.}*

*{Drafting Note: Include the paragraph below if the plan provides out-of-network benefits. Insert the last three bracketed sentences if applicable.}*

[**3.** **Out-of-Network Benefits.** The out-of-network benefits portion of this [Contract; Policy] provides coverage when You receive Covered Services from Non-Participating Providers[ or when You received Covered Services from Participating Providers without care being provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us]. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider’s charge. [The services of Non-Participating Providers inside Our Service Area are not Covered except Emergency Services and Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition, or unless specifically Covered in this [Certificate; Contract; Policy].] [Some Covered Services, such as [insert benefit example], are only Covered when received from Participating Providers and are not Covered as out-of-network benefits. See the Schedule of Benefits section of this [Contract; Policy] for more information.]]

*{Drafting Note: The bracketed PCP language may be used for POS or PPO coverage if the plan requires a PCP referral for in-network services. If the bracketed sentence limiting out-of-network coverage to outside the service area is inserted, the same sentence must also be inserted in paragraph H of the How Your Coverage Works section.}*

***{Drafting Note: Option 3 – Use the paragraph below for EPO or traditional HMO coverage.}***

[**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]. [This [Certificate; Contract; Policy] is issued together with a health insurance [Certificate; Contract; Policy] by [insert insurer’s name] which provides out-of-network Covered Services.] [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 PCP language may be included for EPO or HMO coverage. If the EPO or HMO is issued with a stand-alone out-of-network only product, insert the third sentence with appropriate wording.}*

***{Drafting Note: Option 4 – Use the paragraph below for stand-alone out-of-network only coverage issued with an HMO or EPO network product.}***

[This [Contract; Policy] is issued together with a [HMO; health insurance] [Contract; Policy] by [insert HMO’s or insurer’s name] which provides in-network Covered Services. This [Contract; Policy] provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider’s charge. [The services of Non-Participating Providers inside Our Service Area are not Covered except Emergency Services and Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition, or unless specifically Covered in this [Certificate; Contract; Policy].] [Some Covered Services, such as [insert benefit example], are only Covered when received from Participating Providers and are not Covered as out-of-network benefits. See the Schedule of Benefits section of this [Contract; Policy] for more information.]]

*{Drafting Note: Insert the last three bracketed sentences if applicable. If the bracketed sentence limiting out-of-network coverage to outside the service area is inserted, the same sentence must also be inserted in paragraph F of the How Your Coverage Works section.}*

**READ THIS ENTIRE [CONTRACT; POLICY] CAREFULLY. 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].]