2022 Summary of Benefits

EmblemHealth Bridge Platinum PPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$2,500
Annual Out-of-Pocket Maximum In-Network - Family	$5,000
Annual Plan Year Deductible Out-of-Network - Individual	$2,600
Annual Plan Year Deductible Out-of-Network - Family	$5,200
Annual Out-of-Pocket Maximum Out-of-Network - Individual	$5,000
Annual Out-of-Pocket Maximum Out-of-Network - Family	$10,000
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, free. Thereafter, $15 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$35 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$15 (PCP)/$35 (Specialist) Co-Pay
Diagnostic X-Rays In-Network	$15 (PCP)/$35 (Specialist) Co-Pay
Radiology/Major Diagnostic Test In-network	$15 (PCP)/$35 (Specialist) Co-Pay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$150 Co-Pay
Inpatient Hospital Stay	20% Coinsurance
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$150 Co-Pay
Outpatient Rehabilitation/Therapy In-Network	$15 (PCP)/$35 (Specialist) Co-Pay
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance
Mental/Behavioral Outpatient Services In- Network	First 3 visits, free. Thereafter, $15 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$35 Co-Pay
Durable Medical Equipment	10% Coinsurance
Outpatient Surgery (Facility Fee) In-Network	$150 Co-Pay
Emergency/Urgent Care	
Emergency Room In-Network	$750 Co-Pay
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay
Ambulance	20% Coinsurance
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay
Tier 2 Drug	$30 Co-Pay
Tier 3 Drug	$80 Co-Pay
Annual Prescription Drug Deductible Individual	N/A
Annual Prescription Drug Deductible Family	N/A

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Prime Platinum Premier	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$2,000
Annual Out-of-Pocket Maximum In-Network - Family	$4,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, No Charge. Thereafter, $15 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$35 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$15 (PCP)/$35 (Specialist) Co-Pay
Diagnostic X-Rays In-Network	$15 (PCP)/$35 (Specialist) Co-Pay
Radiology/Major Diagnostic Test In-network	$35 Co-Pay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$250 Co-Pay
Inpatient Hospital Stay	20% Coinsurance, per admission
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$250 Co-Pay
Outpatient Rehabilitation/Therapy In-Network	$15 (PCP)/$35 (Specialist) Co-Pay
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance
Mental/Behavioral Outpatient Services In- Network	First 3 visits, No Charge. Thereafter, $15 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$35 Co-Pay
Durable Medical Equipment	10% Coinsurance
Outpatient Surgery (Facility Fee) In-Network	$250 Co-Pay
Emergency/Urgent Care	
Emergency Room In-Network	$400 Co-Pay
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay
Ambulance	$250 Co-Pay
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay
Tier 2 Drug	$30 Co-Pay
Tier 3 Drug	$65 Co-Pay
Annual Prescription Drug Deductible Individual	N/A
Annual Prescription Drug Deductible Family	N/A

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Select Care Platinum Premier	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$2,000
Annual Out-of-Pocket Maximum In-Network - Family	$4,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, No Charge. Thereafter, $15 Co-Pay
Specialist Visit In-Network	$35 Co-Pay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$15 (PCP)/$35 (Specialist) Co-Pay
Diagnostic X-Rays In-Network	$15 (PCP)/$35 (Specialist) Co-Pay
Radiology/Major Diagnostic Test In-network	$35 Co-Pay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$250 Co-Pay
Inpatient Hospital Stay	20% Coinsurance
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$250 Co-Pay
Outpatient Rehabilitation/Therapy In-Network	$15 (PCP)/$35 (Specialist) Co-Pay
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance
Mental/Behavioral Outpatient Services In- Network	First 3 visits, No Charge. Thereafter, $15 Co-Pay
Chiropractic Services In-Network	$35 Co-Pay
Durable Medical Equipment	10% Coinsurance
Outpatient Surgery (Facility Fee) In-Network	$250 Co-Pay
Emergency/Urgent Care	
Emergency Room In-Network	$400 Co-Pay
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay
Ambulance	$250 Co-Pay
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay
Tier 2 Drug	$30 Co-Pay
Tier 3 Drug	$65 Co-Pay
Annual Prescription Drug Deductible Individual	N/A
Annual Prescription Drug Deductible Family	N/A

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Healthfirst Platinum Pro EPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$2,000
Annual Out-of-Pocket Maximum In-Network - Family	$4,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$20 Co-Pay
Specialist Visit In-Network	$35 Co-Pay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$20 (PCP)/$35 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	$20 (PCP)/$35 (Specialist) Co-Pay (not subject to ded.)
Radiology/Major Diagnostic Test In-network	$20 (PCP)/$35 (Specialist) Co-Pay (not subject to ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$100 Co-Pay
Inpatient Hospital Stay	$500 Co-Pay/admission
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$100 Co-Pay
Outpatient Rehabilitation/Therapy In-Network	$35 Co-Pay
Mental/Behavioral Inpatient Services In-Network	$500 Co-Pay/admission
Mental/Behavioral Outpatient Services In- Network	$20 Co-Pay
Chiropractic Services In-Network	$35 Co-Pay
Durable Medical Equipment	10% Coinsurance
Outpatient Surgery (Facility Fee) In-Network	$200 Co-Pay
Emergency/Urgent Care	
Emergency Room In-Network	$250 Co-Pay
Urgent care (NON-emergency room care) In-Network	$50 Co-Pay
Ambulance	$150 Co-Pay
Prescription Drugs	
Tier 1 Drug	$10 Co-Pay
Tier 2 Drug	$30 Co-Pay
Tier 3 Drug	$60 Co-Pay
Annual Prescription Drug Deductible Individual	$0 Deductible
Annual Prescription Drug Deductible Family	$0 Deductible

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Liberty Platinum EPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$500
Annual Plan Year Deductible In-Network - Family	$1,000
Annual Out-of-Pocket Maximum In-Network - Individual	$3,050
Annual Out-of-Pocket Maximum In-Network - Family	$6,100
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$5 Co-Pay/$25 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$35 Co-Pay/$70 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	0% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	0% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	0% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Inpatient Hospital Stay	0% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$70 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$35 copay (not subject to ded.)
Chiropractic Services In-Network	$35/$70 copay (not subject to ded.)
Durable Medical Equipment	0% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	0% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$250 copay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	75$ copay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 Co-Pay (not subject to ded.)
Tier 2 Drug	$50 Co-Pay (after ded.)
Tier 3 Drug	$90 Co-Pay (after ded.)
Annual Prescription Drug Deductible Individual	$200 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Bridge Gold PPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$1,300
Annual Plan Year Deductible In-Network - Family	$2,600
Annual Out-of-Pocket Maximum In-Network - Individual	$5,500
Annual Out-of-Pocket Maximum In-Network - Family	$11,000
Annual Plan Year Deductible Out-of-Network - Individual	$3,500
Annual Plan Year Deductible Out-of-Network - Family	$7,000
Annual Out-of-Pocket Maximum Out-of-Network - Individual	$7,500
Annual Out-of-Pocket Maximum Out-of-Network - Family	$15,000
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, free. Thereafter, $25 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$40 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (after ded.)
Diagnostic X-Rays In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (after ded.)
Radiology/Major Diagnostic Test In-network	$40 Co-Pay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$200 Co-Pay after deductible
Inpatient Hospital Stay	30% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$200 Co-Pay after deductible
Outpatient Rehabilitation/Therapy In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (after ded.)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	First 3 visits, free. Thereafter, $25 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$40 Co-Pay (not subject to ded.)
Durable Medical Equipment	20% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$200 Co-Pay after deductible
Emergency/Urgent Care	
Emergency Room In-Network	$1,000 Co-Pay (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	30% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay
Tier 2 Drug	$35 Co-Pay
Tier 3 Drug	$100 Co-Pay
Annual Prescription Drug Deductible Individual	N/A
Annual Prescription Drug Deductible Family	N/A

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Prime Gold Premier	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$450
Annual Plan Year Deductible In-Network - Family	$900
Annual Out-of-Pocket Maximum In-Network - Individual	$6,000
Annual Out-of-Pocket Maximum In-Network - Family	$12,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, free. Thereafter, $25 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$40 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (after ded.)
Radiology/Major Diagnostic Test In-network	$40 Co-Pay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Inpatient Hospital Stay	30% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (after ded.)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$25 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$40 Co-Pay (not subject to ded.)
Durable Medical Equipment	20% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$350 Co-Pay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$800 Co-Pay (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	$350 Co-Pay (after ded.)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay
Tier 2 Drug	$40 Co-Pay
Tier 3 Drug	$80 Co-Pay
Annual Prescription Drug Deductible Individual	N/A
Annual Prescription Drug Deductible Family	N/A

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Prime Gold Value	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$2,500
Annual Plan Year Deductible In-Network - Family	$5,000
Annual Out-of-Pocket Maximum In-Network - Individual	$7,000
Annual Out-of-Pocket Maximum In-Network - Family	$14,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	3 Visits No Charge then $25 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$40 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (not subject to ded.)
Radiology/Major Diagnostic Test In-network	$40 Co-Pay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Inpatient Hospital Stay	30% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (after ded.)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	3 Visits No Charge then $25 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$40 Co-Pay (not subject to ded.)
Durable Medical Equipment	20% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$350 Co-Pay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$800 Co-Pay (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	$350 Co-Pay (after ded.)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay (not subject to ded.)
Tier 2 Drug	$40 Co-Pay (after ded.)
Tier 3 Drug	$80 Co-Pay (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Bridge Gold Virtual	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$500
Annual Plan Year Deductible In-Network - Family	$1,000
Annual Out-of-Pocket Maximum In-Network - Individual	$7,800
Annual Out-of-Pocket Maximum In-Network - Family	$15,600
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$40 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$60 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$0 (PCP)/$60 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	$0 (PCP)/$60 (Specialist) Co-Pay (after ded.)
Radiology/Major Diagnostic Test In-network	$60 Co-Pay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Inpatient Hospital Stay	30% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$40 (PCP)/$60 (Specialist) Co-Pay (after ded.)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$40 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$60 Co-Pay (not subject to ded.)
Durable Medical Equipment	20% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$350 Co-Pay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	40% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	$350 Co-Pay (after ded.)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay (not subject to ded.)
Tier 2 Drug	$40 Co-Pay (after ded.)
Tier 3 Drug	$80 Co-Pay (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Select Care Gold Premier	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$450
Annual Plan Year Deductible In-Network - Family	$900
Annual Out-of-Pocket Maximum In-Network - Individual	$6,000
Annual Out-of-Pocket Maximum In-Network - Family	$12,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, free. Thereafter, $25 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$40 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (after ded.)
Radiology/Major Diagnostic Test In-network	$40 Co-Pay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Inpatient Hospital Stay	30% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (after ded.)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$25 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$40 Co-Pay (not subject to ded.)
Durable Medical Equipment	20% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$350 Co-Pay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$800 Co-Pay (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	$350 Co-Pay (after ded.)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay (after ded.)
Tier 2 Drug	$40 Co-Pay (not subject to ded.)
Tier 3 Drug	$80 Co-Pay (after ded.)
Annual Prescription Drug Deductible Individual	N/A
Annual Prescription Drug Deductible Family	N/A

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Select Care Gold Value	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$2,500
Annual Plan Year Deductible In-Network - Family	$5,000
Annual Out-of-Pocket Maximum In-Network - Individual	$7,000
Annual Out-of-Pocket Maximum In-Network - Family	$14,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, $0 Co-Pay. Thereafter, $25 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$40 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	$25 (PCP)/$40 (Specialist) Co-Pay (after ded.)
Radiology/Major Diagnostic Test In-network	$40 Co-Pay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Inpatient Hospital Stay	30% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$25 (PCP)/$40 (Specialist) Co-Pay/visit (after ded.)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	First 3 visits, $0 Co-Pay. Thereafter, $25 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$40 Co-Pay (not subject to ded.)
Durable Medical Equipment	20% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$350 Co-Pay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$800 Co-Pay (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	$350 Co-Pay (after ded.)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay (not subject to ded.)
Tier 2 Drug	$40 Co-Pay (after ded.)
Tier 3 Drug	$80 Co-Pay (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Millennium Gold Virtual	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$1,700
Annual Plan Year Deductible In-Network - Family	$3,400
Annual Out-of-Pocket Maximum In-Network - Individual	$8,200
Annual Out-of-Pocket Maximum In-Network - Family	$16,400
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out of Network- Individual	N/A
Annual Out-of-Pocket Maximum Out of Network- Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$40 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$60 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$0 (PCP)/$60 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	$40 (PCP)/$60 (Specialist) Co-Pay (after ded.)
Radiology/Major Diagnostic Test In-network	$60 Co-Pay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Inpatient Hospital Stay	30% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$40 (PCP)/$60 (Specialist) Co-Pay/visit (after ded.)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$40 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$60 Co-Pay (not subject to ded.)
Durable Medical Equipment	20% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$350 Co-Pay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	40% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	$350 Co-Pay (after ded.)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay (not subject to ded.)
Tier 2 Drug	$40 Co-Pay (after ded.)
Tier 3 Drug	$80 Co-Pay (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Healthfirst Gold Pro EPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$5,275
Annual Out-of-Pocket Maximum In-Network - Family	$10,550
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 Co-Pay
Specialist Visit In-Network	$40 Co-Pay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$25 (PCP)/ $40 (Specialist) Co-Pay
Diagnostic X-Rays In-Network	$25 (PCP)/ $40 (Specialist) Co-Pay
Radiology/Major Diagnostic Test In-network	$25 (PCP)/ $40 (Specialist) Co-Pay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$100 Co-Pay
Inpatient Hospital Stay	$500 Co-Pay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$100 Co-Pay
Outpatient Rehabilitation/Therapy In-Network	$40 Co-Pay
Mental/Behavioral Inpatient Services In-Network	$500 Co-Pay
Mental/Behavioral Outpatient Services In- Network	$25 Co-Pay
Chiropractic Services In-Network	$40 Co-Pay
Durable Medical Equipment	15% Coinsurance
Outpatient Surgery (Facility Fee) In-Network	$300 Co-Pay
Emergency/Urgent Care	
Emergency Room In-Network	$350 Co-Pay
Urgent care (NON-emergency room care) In-Network	$60 Co-Pay
Ambulance	$150 Co-Pay
Prescription Drugs	
Tier 1 Drug	$10 Co-Pay
Tier 2 Drug	$50 Co-Pay
Tier 3 Drug	$85 Co-Pay
Annual Prescription Drug Deductible Individual	$0 Deductible
Annual Prescription Drug Deductible Family	$0 Deductible

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Healthfirst Gold 25/50/0 Pro EPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$7,000
Annual Out-of-Pocket Maximum In-Network - Family	$14,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 Co-Pay
Specialist Visit In-Network	$50 Co-Pay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$25 (PCP)/ $50 (Specialist) Co-Pay
Diagnostic X-Rays In-Network	$25 (PCP)/ $50 (Specialist) Co-Pay
Radiology/Major Diagnostic Test In-network	$25 (PCP)/ $50 (Specialist) Co-Pay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$100 Co-Pay
Inpatient Hospital Stay	$500 Co-Pay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$100 Co-Pay
Outpatient Rehabilitation/Therapy In-Network	$50 Co-Pay
Mental/Behavioral Inpatient Services In-Network	$500 Co-Pay
Mental/Behavioral Outpatient Services In- Network	$25 Co-Pay
Chiropractic Services In-Network	$50 Co-Pay
Durable Medical Equipment	15% Coinsurance
Outpatient Surgery (Facility Fee) In-Network	$300 Co-Pay
Emergency/Urgent Care	
Emergency Room In-Network	$350 Co-Pay
Urgent care (NON-emergency room care) In-Network	$60 Co-Pay
Ambulance	$150 Co-Pay
Prescription Drugs	
Tier 1 Drug	$10 Co-Pay
Tier 2 Drug	$50 Co-Pay
Tier 3 Drug	$85 Co-Pay
Annual Prescription Drug Deductible Individual	$0 Deductible
Annual Prescription Drug Deductible Family	$0 Deductible

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Healthfirst Gold 1350 Pro EPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$1,350
Annual Plan Year Deductible In-Network - Family	$2,700
Annual Out-of-Pocket Maximum In-Network - Individual	$8,150
Annual Out-of-Pocket Maximum In-Network - Family	$16,300
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 Co-Pay
Specialist Visit In-Network	$70 Co-Pay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$25 (PCP)/ $70 (Specialist) Co-Pay
Diagnostic X-Rays In-Network	$25 (PCP)/ $70 (Specialist) Co-Pay
Radiology/Major Diagnostic Test In-network	$25 (PCP)/ $70 (Specialist) Co-Pay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	20% coinsurance after deductible
Inpatient Hospital Stay	20% coinsurance after deductible
Outpatient Surgery (Physician/Surgeon Fee) In-Network	20% coinsurance after deductible
Outpatient Rehabilitation/Therapy In-Network	$70 Co-Pay
Mental/Behavioral Inpatient Services In-Network	20% coinsurance after deductible
Mental/Behavioral Outpatient Services In- Network	$25 Co-Pay
Chiropractic Services In-Network	$70 Co-Pay
Durable Medical Equipment	20% coinsurance after deductible
Outpatient Surgery (Facility Fee) In-Network	20% coinsurance after deductible
Emergency/Urgent Care	
Emergency Room In-Network	$600 Co-Pay after deductible
Urgent care (NON-emergency room care) In-Network	$60 Co-Pay
Ambulance	$150 Co-Pay
Prescription Drugs	
Tier 1 Drug	$20 Co-Pay
Tier 2 Drug	$60 Co-Pay
Tier 3 Drug	$110 Co-Pay
Annual Prescription Drug Deductible Individual	$0 Deductible
Annual Prescription Drug Deductible Family	$0 Deductible

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Metro Gold EPO 25/40 G	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$1,250
Annual Plan Year Deductible In-Network - Family	$2,500
Annual Out-of-Pocket Maximum In-Network - Individual	$6,000
Annual Out-of-Pocket Maximum In-Network - Family	$12,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 copay (not subject to ded.)
Specialist Visit In-Network	$40 copay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$15 copay (not subject to ded.)
Diagnostic X-Rays In-Network	$50 copay (not subject to ded.)
Radiology/Major Diagnostic Test In-network	$150 copay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	20% Coinsurance (after ded.)
Inpatient Hospital Stay	20% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	20% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$40 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$40 copay (not subject to ded.)
Chiropractic Services In-Network	$40 copay (not subject to ded.)
Durable Medical Equipment	20% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$200 copay at Physicians Office (after ded.), $500 copay at Hospital (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	$65 copay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$65 copay (after ded.)
Tier 3 Drug	$90 copay (after ded.)
Annual Prescription Drug Deductible Individual	$150 Deductible/member
Annual Prescription Drug Deductible Family	$150 Deductible/member

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Metro Gold EPO 25/40	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$1,250
Annual Plan Year Deductible In-Network - Family	$2,500
Annual Out-of-Pocket Maximum In-Network - Individual	$6,000
Annual Out-of-Pocket Maximum In-Network - Family	$12,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 copay (not subject to ded.)
Specialist Visit In-Network	$40 copay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$15 copay (not subject to ded.)
Diagnostic X-Rays In-Network	$50 copay (after ded.)
Radiology/Major Diagnostic Test In-network	$150 copay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	20% Coinsurance (after ded.)
Inpatient Hospital Stay	20% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	20% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$40 copay/visit (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$40 copay/visit (not subject to ded.)
Chiropractic Services In-Network	$40 copay (not subject to ded.)
Durable Medical Equipment	20% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$200 copay at Physicians Office (after ded.), $500 copay at Hospital (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	$65 copay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$65 copay (after ded.)
Tier 3 Drug	$95 copay (after ded.)
Annual Prescription Drug Deductible Individual	$150 Deductible/member
Annual Prescription Drug Deductible Family	$150 Deductible/member

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Liberty Gold EPO 30/60	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$2,000
Annual Plan Year Deductible In-Network - Family	$4,000
Annual Out-of-Pocket Maximum In-Network - Individual	$8,400
Annual Out-of-Pocket Maximum In-Network - Family	$16,800
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$30 copay (not subject to ded.)
Specialist Visit In-Network	$60 copay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	No Charge
Diagnostic X-Rays In-Network	30% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	30% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded.)
Inpatient Hospital Stay	30% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$60 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$60 copay (not subject to ded.)
Chiropractic Services In-Network	$60 copay (not subject to ded.)
Durable Medical Equipment	30% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	30% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	$75 copay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$50 copay (after ded.)
Tier 3 Drug	$90 copay (after ded.)
Annual Prescription Drug Deductible Individual	$200 Deductible/member
Annual Prescription Drug Deductible Family	$200 Deductible/member

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Liberty Gold EPO 30/60 G	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$1,250
Annual Plan Year Deductible In-Network - Family	$2,500
Annual Out-of-Pocket Maximum In-Network - Individual	$6,400
Annual Out-of-Pocket Maximum In-Network - Family	$12,800
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$30 copay
Specialist Visit In-Network	$60 copay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	No Charge
Diagnostic X-Rays In-Network	$35 copay
Radiology/Major Diagnostic Test In-network	$100 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Inpatient Hospital Stay	$500 copay/day ($2000 max) (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$60 copay/visit (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	$500 copay/day ($2000 max) (after ded.)
Mental/Behavioral Outpatient Services In- Network	$60 copay (not subject to ded.)
Chiropractic Services In-Network	$60 copay (after ded.)
Durable Medical Equipment	0% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$150 copay at Physician Office(after ded.), $250 copay at Hospital (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	$75 copay (not subjet to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$50 copay (after ded.)
Tier 3 Drug	$90 copay (after ded.)
Annual Prescription Drug Deductible Individual	$200 Deductible/member
Annual Prescription Drug Deductible Family	$200 Deductible/member

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Liberty Gold EPO 25/50 ZD	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$6,000
Annual Out-of-Pocket Maximum In-Network - Family	$12,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 copay
Specialist Visit In-Network	$50 copay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$20 copay
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$150 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay per visit
Inpatient Hospital Stay	$500 copay per admission
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$75 copay at Physicians Office, $250 copay at Hospital
Outpatient Rehabilitation/Therapy In-Network	$50 copay
Mental/Behavioral Inpatient Services In-Network	$500 copay
Mental/Behavioral Outpatient Services In- Network	$50 copay
Chiropractic Services In-Network	$50 copay
Durable Medical Equipment	No Charge
Outpatient Surgery (Facility Fee) In-Network	$150 copay at Physicians Office, $500 copay at Hospital
Emergency/Urgent Care	
Emergency Room In-Network	$750 copay
Urgent care (NON-emergency room care) In-Network	$50 copay
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$50 copay (after ded.)
Tier 3 Drug	$90 copay (after ded.)
Annual Prescription Drug Deductible Individual	$200 Deductible/member
Annual Prescription Drug Deductible Family	$200 Deductible/member

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Liberty Gold HSA 1500 Motion	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$1,500
Annual Plan Year Deductible In-Network - Family	$3,000
Annual Out-of-Pocket Maximum In-Network - Individual	$5,500
Annual Out-of-Pocket Maximum In-Network - Family	$11,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	10% Coinsurance (after ded.)
Specialist Visit In-Network	10% Coinsurance (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	10% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	10% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	10% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	10% Coinsurance (after ded.)
Inpatient Hospital Stay	10% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	10% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	10% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	10% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	10% Coinsurance (after ded.)
Chiropractic Services In-Network	10% Coinsurance (after ded.)
Durable Medical Equipment	10% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	10% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	10% Coinsurance (after ded.)
Ambulance	10% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$10 copay (after ded.)
Tier 2 Drug	$50 copay (after ded.)
Tier 3 Drug	$90 copay (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/Medical
Annual Prescription Drug Deductible Family	Combined w/Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Prime Silver Premier	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$3,800
Annual Plan Year Deductible In-Network - Family	$7,600
Annual Out-of-Pocket Maximum In-Network - Individual	$8,000
Annual Out-of-Pocket Maximum In-Network - Family	$16,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, free. Thereafter, $35 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$65 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$35 (PCP)/$65 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	$35 (PCP)/$65 (Specialist) Co-Pay (after ded.)
Radiology/Major Diagnostic Test In-network	$65 (Specialist) Co-Pay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Inpatient Hospital Stay	40% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$35 (PCP)/$65 (Specialist) Co-Pay (after ded.)
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$35 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$65 Co-Pay (not subject to ded.)
Durable Medical Equipment	30% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$350 Co-Pay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	40% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	$350 Co-Pay (after ded.)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay
Tier 2 Drug	$40 Co-Pay
Tier 3 Drug	$80 Co-Pay
Annual Prescription Drug Deductible Individual	N/A
Annual Prescription Drug Deductible Family	N/A

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Select Care Silver Premier	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$3,800
Annual Plan Year Deductible In-Network - Family	$7,600
Annual Out-of-Pocket Maximum In-Network - Individual	$8,000
Annual Out-of-Pocket Maximum In-Network - Family	$16,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, free. Thereafter, $35 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$65 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$35 (PCP)/$65 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	$35 (PCP)/$65 (Specialist) Co-Pay (after ded.)
Radiology/Major Diagnostic Test In-network	$35 (PCP)/$65 (Specialist) Co-Pay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Inpatient Hospital Stay	40% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$35 (PCP)/$65 (Specialist) Co-Pay (after ded.)
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$35 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$65 Co-Pay (not subject to ded.)
Durable Medical Equipment	30% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$350 Co-Pay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	40% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	$350 Co-Pay (after ded.)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay
Tier 2 Drug	$40 Co-Pay
Tier 3 Drug	$80 Co-Pay
Annual Prescription Drug Deductible Individual	N/A
Annual Prescription Drug Deductible Family	N/A

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Select Care Silver Value	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$7,000
Annual Plan Year Deductible In-Network - Family	$14,000
Annual Out-of-Pocket Maximum In-Network - Individual	$7,000
Annual Out-of-Pocket Maximum In-Network - Family	$14,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, free. Thereafter, $10 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$55 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$10 (PCP)/$55 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	0% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	0% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Inpatient Hospital Stay	0% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$10 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$55 Co-Pay (not subject to ded.)
Durable Medical Equipment	0% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	0% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	0% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	0% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay (not subject to ded.)
Tier 2 Drug	$0 Co-Pay (after ded.)
Tier 3 Drug	$0 Co-Pay (after ded.)
Annual Prescription Drug Deductible Individual	N/A
Annual Prescription Drug Deductible Family	N/A

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Millennium Silver Value G	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$7,000
Annual Plan Year Deductible In-Network - Family	$14,000
Annual Out-of-Pocket Maximum In-Network - Individual	$7,000
Annual Out-of-Pocket Maximum In-Network - Family	$14,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, free. Thereafter, $10 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$55 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$10 (PCP)/$55 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	0% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	0% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Inpatient Hospital Stay	0% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	First 3 visits, free. Thereafter, $10 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$55 Co-Pay (not subject to ded.)
Durable Medical Equipment	0% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	0% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	0% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	0% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay (not subject to ded.)
Tier 2 Drug	$0 Co-Pay (after ded.)
Tier 3 Drug	$0 Co-Pay (after ded.)
Annual Prescription Drug Deductible Individual	N/A
Annual Prescription Drug Deductible Family	N/A

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Prime Silver HSA	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$3,000
Annual Plan Year Deductible In-Network - Family	$6,000
Annual Out-of-Pocket Maximum In-Network - Individual	$6,800
Annual Out-of-Pocket Maximum In-Network - Family	$13,600
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$30 Co-Pay (after ded.)
Specialist Visit In-Network	$50 Co-Pay (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$30 (PCP)/$50 (Specialist) Co-Pay (after ded.)
Diagnostic X-Rays In-Network	$30 (PCP)/$50 (Specialist) Co-Pay (after ded.)
Radiology/Major Diagnostic Test In-network	$50 Co-Pay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Inpatient Hospital Stay	40% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 Co-Pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$30 (PCP)/$50 (Specialist) Co-Pay (after ded.)
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$30 Co-Pay (after ded.)
Chiropractic Services In-Network	$50 Co-Pay (after ded.)
Durable Medical Equipment	30% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$350 Co-Pay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	40% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$100 Co-Pay (after ded.)
Ambulance	$350 Co-Pay (after ded.)
Prescription Drugs	
Tier 1 Drug	$15 Co-Pay (after ded.)
Tier 2 Drug	$45 Co-Pay (after ded.)
Tier 3 Drug	$80 Co-Pay (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Healthfirst Silver Pro EPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$4,300
Annual Plan Year Deductible In-Network - Family	$8,600
Annual Out-of-Pocket Maximum In-Network - Individual	$8,150
Annual Out-of-Pocket Maximum In-Network - Family	$16,300
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$35 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$70 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$35 (PCP)/ $70 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	$35 (PCP)/ $70 (Specialist) Co-Pay (not subject to ded.)
Radiology/Major Diagnostic Test In-network	$35 (PCP)/ $70 (Specialist) Co-Pay (not subject to ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$200 Co-Pay (after ded.)
Inpatient Hospital Stay	40% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$200 Co-Pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$70 Co-Pay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$35 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$70 Co-Pay (not subject to ded.)
Durable Medical Equipment	40% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	40% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$600 Co-Pay (after ded.)
Urgent care (NON-emergency room care) In-Network	$70 Co-Pay (not subject to ded.)
Ambulance	$300 Co-Pay (after ded.)
Prescription Drugs	
Tier 1 Drug	$20 Co-Pay
Tier 2 Drug	$60 Co-Pay
Tier 3 Drug	$110 Co-Pay
Annual Prescription Drug Deductible Individual	$0 Deductible
Annual Prescription Drug Deductible Family	$0 Deductible

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Healthfirst Silver 40/75/4700 Pro EPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$4,700
Annual Plan Year Deductible In-Network - Family	$9,400
Annual Out-of-Pocket Maximum In-Network - Individual	$7,900
Annual Out-of-Pocket Maximum In-Network - Family	$15,800
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$40 Co-Pay (not subject to ded.)
Specialist Visit In-Network	$75 Co-Pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge (not subject to ded.)
Diagnostic Lab Work In-Network	$40 (PCP)/ $75 (Specialist) Co-Pay (not subject to ded.)
Diagnostic X-Rays In-Network	$40 (PCP)/ $75 (Specialist) Co-Pay (not subject to ded.)
Radiology/Major Diagnostic Test In-network	$40 (PCP)/ $75 (Specialist) Co-Pay (not subject to ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$200 Co-Pay (after ded.)
Inpatient Hospital Stay	45% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$200 Co-Pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$75 Co-Pay
Mental/Behavioral Inpatient Services In-Network	45% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$40 Co-Pay (not subject to ded.)
Chiropractic Services In-Network	$75 Co-Pay (not subject to ded.)
Durable Medical Equipment	45% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	45% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$600 Co-Pay (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	$300 Co-Pay (after ded.)
Prescription Drugs	
Tier 1 Drug	$20 Co-Pay
Tier 2 Drug	$60 Co-Pay
Tier 3 Drug	$110 Co-Pay
Annual Prescription Drug Deductible Individual	$0 Deductible
Annual Prescription Drug Deductible Family	$0 Deductible

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Metro Silver EPO 30/80 G	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$3,500
Annual Plan Year Deductible In-Network - Family	$7,000
Annual Out-of-Pocket Maximum In-Network - Individual	$8,700
Annual Out-of-Pocket Maximum In-Network - Family	$17,400
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$30 copay (not subject to ded.)
Specialist Visit In-Network	$80 copay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$20 copay (not subject to ded.)
Diagnostic X-Rays In-Network	30% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	30% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded.)
Inpatient Hospital Stay	30% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$80 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$80 copay (not subject to ded.)
Chiropractic Services In-Network	$80 copay (not subject to ded.)
Durable Medical Equipment	30% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	30% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$80 copay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$65 copay (after ded.)
Tier 3 Drug	$95 copay (after ded.)
Annual Prescription Drug Deductible Individual	$150 Deductible/member
Annual Prescription Drug Deductible Family	$150 Deductible/member

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Metro Silver EPO 50/100 ZD	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$8,700
Annual Out-of-Pocket Maximum In-Network - Family	$17,400
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$50 copay
Specialist Visit In-Network	$100 copay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$40 copay
Diagnostic X-Rays In-Network	$150 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$500 copay
Inpatient Hospital Stay	$1000 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay at Physicians Office, $350 copay at Hospital
Outpatient Rehabilitation/Therapy In-Network	$100 copay
Mental/Behavioral Inpatient Services In-Network	$1000 copay
Mental/Behavioral Outpatient Services In- Network	$100 copay
Chiropractic Services In-Network	$100 copay
Durable Medical Equipment	No Charge
Outpatient Surgery (Facility Fee) In-Network	$500 copay at Physicians Office, $700 copay at Hospital
Emergency/Urgent Care	
Emergency Room In-Network	$1400 copay
Urgent care (NON-emergency room care) In-Network	$100 copay
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$65 copay (after ded.)
Tier 3 Drug	$95 copay (after ded.)
Annual Prescription Drug Deductible Individual	$150 Deductible/member
Annual Prescription Drug Deductible Family	$150 Deductible/member

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Liberty Silver EPO 25/50 G	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$4,500
Annual Plan Year Deductible In-Network - Family	$9,000
Annual Out-of-Pocket Maximum In-Network - Individual	$8,700
Annual Out-of-Pocket Maximum In-Network - Family	$17,400
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 copay (not subject to ded.)
Specialist Visit In-Network	$50 copay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$15 copay (not subject to ded.)
Diagnostic X-Rays In-Network	50% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	50% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Inpatient Hospital Stay	50% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$50 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$50 copay (not subject to ded.)
Chiropractic Services In-Network	$50 copay (not subject to ded.)
Durable Medical Equipment	50% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$80 copay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$50 copay (after ded.)
Tier 3 Drug	$90 copay (after ded.)
Annual Prescription Drug Deductible Individual	$200 Deductible/member
Annual Prescription Drug Deductible Family	$200 Deductible/member

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Liberty Silver EPO 40/70	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$3,000
Annual Plan Year Deductible In-Network - Family	$6,000
Annual Out-of-Pocket Maximum In-Network - Individual	$8,700
Annual Out-of-Pocket Maximum In-Network - Family	$17,400
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$40 copay (not subject to ded.)
Specialist Visit In-Network	$70 copay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$25 copay (not subject to ded.)
Diagnostic X-Rays In-Network	35% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	35% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	35% Coinsurance (after ded.)
Inpatient Hospital Stay	35% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	35% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$70 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	35% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$70 copay (not subject to ded.)
Chiropractic Services In-Network	$70 copay (not subject to ded.)
Durable Medical Equipment	35% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	35% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 copay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$50 copay (after ded.)
Tier 3 Drug	$90 copay (after ded.)
Annual Prescription Drug Deductible Individual	$200 Deductible/member
Annual Prescription Drug Deductible Family	$200 Deductible/member

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Liberty Silver EPO 50/100 ZD	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$8,700
Annual Out-of-Pocket Maximum In-Network - Family	$17,400
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$50 copay
Specialist Visit In-Network	$100 copay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$40 copay
Diagnostic X-Rays In-Network	$150 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$500 copay
Inpatient Hospital Stay	$1000 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay Physician's Office, $350 copay Hospital Setting
Outpatient Rehabilitation/Therapy In-Network	$100 copay
Mental/Behavioral Inpatient Services In-Network	$1000 copay
Mental/Behavioral Outpatient Services In- Network	$100 copay
Chiropractic Services In-Network	$100 copay
Durable Medical Equipment	No Charge
Outpatient Surgery (Facility Fee) In-Network	$500 copay Physician's Office, $700 copay Hospital Setting
Emergency/Urgent Care	
Emergency Room In-Network	$1400 copay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	$100 copay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$65 copay (after ded.)
Tier 3 Drug	$95 copay (after ded.)
Annual Prescription Drug Deductible Individual	$150 Deductible/member
Annual Prescription Drug Deductible Family	$150 Deductible/member

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Liberty Silver HSA 4000 Motion	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$4,000
Annual Plan Year Deductible In-Network - Family	$8,000
Annual Out-of-Pocket Maximum In-Network - Individual	$7,050
Annual Out-of-Pocket Maximum In-Network - Family	$14,100
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	20% Coinsurance (after ded.)
Specialist Visit In-Network	20% Coinsurance (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	20% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	20% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	20% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	20% Coinsurance (after ded.)
Inpatient Hospital Stay	20% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	20% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	20% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	20% Coinsurance (after ded.)
Chiropractic Services In-Network	20% Coinsurance (after ded.)
Durable Medical Equipment	20% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	20% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	20% Coinsurance (after ded.)
Ambulance	20% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$10 copay (after ded.)
Tier 2 Drug	$50 copay (after ded.)
Tier 3 Drug	$90 copay (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/Medical
Annual Prescription Drug Deductible Family	Combined w/Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Prime Bronze HSA	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$6,300
Annual Plan Year Deductible In-Network - Family	$12,600
Annual Out-of-Pocket Maximum In-Network - Individual	$6,900
Annual Out-of-Pocket Maximum In-Network - Family	$13,800
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	50% Coinsurance (after ded.)
Specialist Visit In-Network	50% Coinsurance (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	50% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	50% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	50% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Inpatient Hospital Stay	50% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	50% Coinsurance (after ded.)
Chiropractic Services In-Network	50% Coinsurance (after ded.)
Durable Medical Equipment	50% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$100 Co-Pay (after ded.)
Ambulance	50% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$15 Co-Pay (after ded.)
Tier 2 Drug	$65 Co-Pay (after ded.)
Tier 3 Drug	$80 Co-Pay (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Select Care Bronze Premier	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$5,500
Annual Plan Year Deductible In-Network - Family	$11,000
Annual Out-of-Pocket Maximum In-Network - Individual	$8,700
Annual Out-of-Pocket Maximum In-Network - Family	$17,400
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, $0 Co-Pay. Thereafter, 50% Coinsurance (after ded.)
Specialist Visit In-Network	50% Coinsurance (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	50% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	50% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	50% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Inpatient Hospital Stay	50% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	First 3 visits, $0 Co-Pay. Thereafter, 50% Coinsurance (after ded.)
Chiropractic Services In-Network	50% Coinsurance (after ded.)
Durable Medical Equipment	50% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	50% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$50 Co-Pay (not subject to ded.)
Tier 2 Drug	50% Coinsurance (after ded.)
Tier 3 Drug	50% Coinsurance (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Select Care Bronze Value	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$8,550
Annual Plan Year Deductible In-Network - Family	$17,100
Annual Out-of-Pocket Maximum In-Network - Individual	$8,550
Annual Out-of-Pocket Maximum In-Network - Family	$17,100
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, $0 Co-Pay. Thereafter, 0% Coinsurance (after ded)
Specialist Visit In-Network	0% Coinsurance (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	0% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	0% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	0% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Inpatient Hospital Stay	0% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	First 3 visits, $0 Co-Pay. Thereafter, 0% Coinsurance (after ded)
Chiropractic Services In-Network	0% Coinsurance (after ded.)
Durable Medical Equipment	0% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	0% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	0% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	0% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$35 Co-Pay (not subject to ded.)
Tier 2 Drug	0% Coinsurance (after ded.)
Tier 3 Drug	0% Coinsurance (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Millennium Bronze Premier G	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$5,500
Annual Plan Year Deductible In-Network - Family	$11,000
Annual Out-of-Pocket Maximum In-Network - Individual	$8,700
Annual Out-of-Pocket Maximum In-Network - Family	$17,400
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/a
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, $0 Co-Pay. Thereafter, 50% Coinsurance (after ded.)
Specialist Visit In-Network	50% Coinsurance (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	50% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	50% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	50% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Inpatient Hospital Stay	50% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	First 3 visits, $0 Co-Pay. Thereafter, 50% Coinsurance (after ded.)
Chiropractic Services In-Network	50% Coinsurance (after ded.)
Durable Medical Equipment	50% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	50% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$50 Co-Pay (not subject to ded.)
Tier 2 Drug	50% Coinsurance (after ded.)
Tier 3 Drug	50% Coinsurance (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

EmblemHealth Millennium Bronze Value G	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$8,550
Annual Plan Year Deductible In-Network - Family	$17,100
Annual Out-of-Pocket Maximum In-Network - Individual	$8,550
Annual Out-of-Pocket Maximum In-Network - Family	$17,100
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, $0 Co-Pay. Thereafter, 0% Coinsurance (after ded.)
Specialist Visit In-Network	0% Coinsurance (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	0% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	0% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	0% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Inpatient Hospital Stay	0% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	First 3 visits, $0 Co-Pay. Thereafter, 0% Coinsurance (after ded.)
Chiropractic Services In-Network	0% Coinsurance (after ded.)
Durable Medical Equipment	0% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	0% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	0% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$75 Co-Pay (not subject to ded.)
Ambulance	0% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$35 Co-Pay (not subject to ded.)
Tier 2 Drug	0% Coinsurance (after ded.)
Tier 3 Drug	0% Coinsurance (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Healthfirst Bronze Pro EPO HSA	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$5,950
Annual Plan Year Deductible In-Network - Family	$11,900
Annual Out-of-Pocket Maximum In-Network - Individual	$6,900
Annual Out-of-Pocket Maximum In-Network - Family	$13,800
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	50% Coinsurance (after ded.)
Specialist Visit In-Network	50% Coinsurance (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	50% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	50% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	50% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Inpatient Hospital Stay	50% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	50% Coinsurance (after ded.)
Chiropractic Services In-Network	50% Coinsurance (after ded.)
Durable Medical Equipment	50% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	50% Coinsurance (after ded.)
Ambulance	50% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	50% Coinsurance (after ded.)
Tier 2 Drug	50% Coinsurance (after ded.)
Tier 3 Drug	50% Coinsurance (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Healthfirst Bronze 5250 Pro EPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$5,250
Annual Plan Year Deductible In-Network - Family	$10,500
Annual Out-of-Pocket Maximum In-Network - Individual	$8,550
Annual Out-of-Pocket Maximum In-Network - Family	$17,100
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$0 Copay (not subject to deductible for first 3 visits.) 50% Coinsurance (after ded.)
Specialist Visit In-Network	50% Coinsurance(after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	50% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	50% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	50% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Inpatient Hospital Stay	50% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	50% Coinsurance (not subject to deductible for first 3 visits) 50% Coinsurance (after ded.)
Chiropractic Services In-Network	50% Coinsurance (after ded.)
Durable Medical Equipment	50% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	50% Coinsurance (after ded.)
Ambulance	50% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	50% Coinsurance (after ded.)
Tier 2 Drug	50% Coinsurance (after ded.)
Tier 3 Drug	50% Coinsurance (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Healthfirst Bronze 6850 Pro EPO HSA	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$6,850
Annual Plan Year Deductible In-Network - Family	$13,700
Annual Out-of-Pocket Maximum In-Network - Individual	$6,850
Annual Out-of-Pocket Maximum In-Network - Family	$13,700
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	0% Coinsurance (after ded.)
Specialist Visit In-Network	0% Coinsurance (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	0% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	0% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	0% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Inpatient Hospital Stay	0% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	0% Coinsurance (after ded.)
Chiropractic Services In-Network	0% Coinsurance (after ded.)
Durable Medical Equipment	0% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	0% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	0% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	0% Coinsurance (after ded.)
Ambulance	0% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	0% Coinsurance (after ded.)
Tier 2 Drug	0% Coinsurance (after ded.)
Tier 3 Drug	0% Coinsurance (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Healthfirst Bronze 8225 Pro EPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$8,225
Annual Plan Year Deductible In-Network - Family	$16,450
Annual Out-of-Pocket Maximum In-Network - Individual	$8,225
Annual Out-of-Pocket Maximum In-Network - Family	$16,450
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	0% Coinsurance (after ded.)
Specialist Visit In-Network	0% Coinsurance(after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	0% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	0% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	0% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Inpatient Hospital Stay	0% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	0% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	0% Coinsurance (after ded.)
Chiropractic Services In-Network	0% Coinsurance (after ded.)
Durable Medical Equipment	0% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	0% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	0% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	0% Coinsurance (after ded.)
Ambulance	0% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	0% Coinsurance (after ded.)
Tier 2 Drug	0% Coinsurance (after ded.)
Tier 3 Drug	0% Coinsurance (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Metro Bronze HSA 7000 G	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$7,000
Annual Plan Year Deductible In-Network - Family	$14,000
Annual Out-of-Pocket Maximum In-Network - Individual	$7,050
Annual Out-of-Pocket Maximum In-Network - Family	$14,100
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	0% coinsurance (after ded.)
Specialist Visit In-Network	0% coinsurance (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	0% coinsurance (after ded.)
Diagnostic X-Rays In-Network	0% coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	0% coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Inpatient Hospital Stay	0% coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	0% coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	0% coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	0% coinsurance (after ded.)
Chiropractic Services In-Network	0% coinsurance (after ded.)
Durable Medical Equipment	0% coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	0% coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	0% coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	0% coinsurance (after ded.)
Ambulance	0% coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	0% coinsurance (after ded.)
Tier 2 Drug	0% coinsurance (after ded.)
Tier 3 Drug	0% coinsurance (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/Medical
Annual Prescription Drug Deductible Family	Combined w/Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

2022 Summary of Benefits

Oxford Liberty Bronze HSA 5750	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$5,750
Annual Plan Year Deductible In-Network - Family	$11,500
Annual Out-of-Pocket Maximum In-Network - Individual	$7,050
Annual Out-of-Pocket Maximum In-Network - Family	$14,100
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 copay (after ded.)
Specialist Visit In-Network	$75 copay (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	30% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	30% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	30% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded.)
Inpatient Hospital Stay	30% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$75 copay (after ded.)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$75 copay (after ded.)
Chiropractic Services In-Network	$75 copay (after ded.)
Durable Medical Equipment	30% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	30% Coinsurance (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	30% Coinsurance (after ded.)
Ambulance	30% Coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	30% Coinsurance (after ded.)
Tier 2 Drug	30% Coinsurance (after ded.)
Tier 3 Drug	30% Coinsurance (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/Medical
Annual Prescription Drug Deductible Family	Combined w/Medical

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.