Summary of Benefits

EmblemHealth Prime Platinum PPO Reimbursed at 80% of FAIR Health	
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	$15 co-pay
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	$0 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

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, 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	$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	$15 co-pay
Chiropractic Services In-Network	$35 co-pay
Durable Medical Equipment	10% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$250 copayment
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	$0 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

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, free (INN). 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	$15 (PCP)/$35 (Specialist) 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	$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	$0 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

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 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

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	$2,800
Annual Out-of-Pocket Maximum In-Network - Family	$5,600
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	$5/$25 (not subject to ded.)
Specialist Visit In-Network	$35/$70 (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	No Charge
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	$35 co-pay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	0% coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$35 co-pay (not subject to ded.)
Chiropractic Services In-Network	$35/$70 (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	$250 co-pay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	75$ co-pay (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 ded./member
Annual Prescription Drug Deductible Family	$200 ded./member

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

Summary of Benefits

EmblemHealth Prime Gold PPO Reimbursed at 80% of FAIR Health	
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	$25 (PCP)/$40 (Specialist) 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	$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	$0 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

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	$5,600
Annual Out-of-Pocket Maximum In-Network - Family	$11,200
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	$25 (PCP)/$40 (Specialist) 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	$0 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

Summary of Benefits

EmblemHealth Prime 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	$40 (PCP)/$60 (Specialist) co-pay (after ded.)
Radiology/Major Diagnostic Test In-network	$40 (PCP)/$60 (Specialist) 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	$40 (PCP)/$60 (Specialist) 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	One external prosthetic device per limb per
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 (not subject to ded.)
Tier 3 Drug	$80 co-pay (not subject to 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.

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	$5,600
Annual Out-of-Pocket Maximum In-Network - Family	$11,200
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	$25 (PCP)/$40 (Specialist) 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	$0 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

Summary of Benefits

EmblemHealth Select Care Gold Value	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$2,300
Annual Plan Year Deductible In-Network - Family	$4,600
Annual Out-of-Pocket Maximum In-Network - Individual	$5,300
Annual Out-of-Pocket Maximum In-Network - Family	$10,600
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	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	$25 (PCP)/$40 (Specialist) 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	$25 (PCP)/$40 (Specialist) 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	$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.

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	$40 (PCP)/$60 (Specialist) 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	$40 (PCP)/$60 (Specialist) co-pay/visit (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	One external prosthetic device per limb per lifetime with coverage for repairs and replacement. No orthotics.
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 (not subject to ded.)
Tier 3 Drug	$80 co-pay (not subject to 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.

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	$5,250
Annual Out-of-Pocket Maximum In-Network - Family	$10,500
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	$100 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 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

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 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

Summary of Benefits

Oscar Circle Gold 2000	
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	$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 co-pay
Specialist Visit In-Network	$50 co-pay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$50 co-pay
Diagnostic X-Rays In-Network	$100 co-pay
Radiology/Major Diagnostic Test In-network	$200 co-pay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$150 co-pay (after ded.)
Inpatient Hospital Stay	20% coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$200 co-pay
Outpatient Rehabilitation/Therapy In-Network	$25 co-pay
Mental/Behavioral Inpatient Services In-Network	$25 co-pay
Mental/Behavioral Outpatient Services In- Network	$25 co-pay
Chiropractic Services In-Network	$50 co-pay
Durable Medical Equipment	20% coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$300 co-pay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$350 co-pay
Urgent care (NON-emergency room care) In-Network	$75 co-pay
Ambulance	$650 co-pay
Prescription Drugs	
Tier 1 Drug	$10 co-pay (not subject to ded.)
Tier 2 Drug	$50 co-pay (after ded.)
Tier 3 Drug	$100 co-pay (after ded.)
Annual Prescription Drug Deductible Individual	150
Annual Prescription Drug Deductible Family	300

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

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	$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	$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	$15 co-pay (not subject to ded.)
Diagnostic X-Rays In-Network	$50 co-pay (not subject to ded.)
Radiology/Major Diagnostic Test In-network	$150 co-pay (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 co-pay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	20% coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$40 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 at Physicians Office (after ded.), $500 co-pay at Hospital (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$500 co-pay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	$65 co-pay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 co-pay (not subject to ded.)
Tier 2 Drug	$65 co-pay (after ded.)
Tier 3 Drug	$95 co-pay (after ded.)
Annual Prescription Drug Deductible Individual	$150 ded./member
Annual Prescription Drug Deductible Family	$150 ded./member

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

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	$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	$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	$15 co-pay (not subject to ded.)
Diagnostic X-Rays In-Network	$50 co-pay (after ded.)
Radiology/Major Diagnostic Test In-network	$150 co-pay (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 co-pay/visit (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	20% coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$40 co-pay/visit (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 at Physicians Office (after ded.), $500 co-pay at Hospital (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$500 co-pay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	$65 co-pay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 co-pay (not subject to ded.)
Tier 2 Drug	$65 co-pay (after ded.)
Tier 3 Drug	$95 co-pay (after ded.)
Annual Prescription Drug Deductible Individual	$150 ded./member
Annual Prescription Drug Deductible Family	$150 ded./member

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

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	$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	$30 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 (not subjecr to ded.)
Diagnostic Lab Work In-Network	No Charge (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	$60 co-pay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	30% coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$60 co-pay (not subject to ded.)
Chiropractic Services In-Network	$60 co-pay (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 co-pay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	$75 co-pay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$15 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 ded./member
Annual Prescription Drug Deductible Family	$200 ded./member

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

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	$5,900
Annual Out-of-Pocket Maximum In-Network - Family	$11,800
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 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	No Charge
Diagnostic X-Rays In-Network	$35 co-pay (after ded.)
Radiology/Major Diagnostic Test In-network	$100 co-pay (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Inpatient Hospital Stay	$500 co-pay/day ($2000 max) (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$60 co-pay/visit (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	$500 co-pay/day ($2000 max) (after ded.)
Mental/Behavioral Outpatient Services In- Network	$60 co-pay (not subject to ded.)
Chiropractic Services In-Network	$60 co-pay (after ded.)
Durable Medical Equipment	0% coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$150 co-pay at Physician Office(after ded.), $250 co-pay at Hospital (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$500 co-pay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	$75 co-pay (not subjet to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$15 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 ded./member
Annual Prescription Drug Deductible Family	$200 ded./member

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

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	$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	$25 co-pay
Specialist Visit In-Network	$50 co-pay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$20 co-pay
Diagnostic X-Rays In-Network	$50 co-pay
Radiology/Major Diagnostic Test In-network	$150 co-pay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$500 co-pay
Inpatient Hospital Stay	$500 co-pay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$75 co-pay at Physicians Office, $250 co-pay at Hospital
Outpatient Rehabilitation/Therapy In-Network	$80 co-pay
Mental/Behavioral Inpatient Services In-Network	$500 co-pay
Mental/Behavioral Outpatient Services In- Network	$50 co-pay
Chiropractic Services In-Network	$50 co-pay
Durable Medical Equipment	No Charge
Outpatient Surgery (Facility Fee) In-Network	$150 co-pay at Physicians Office, $500 co-pay at Hospital
Emergency/Urgent Care	
Emergency Room In-Network	$750 co-pay
Urgent care (NON-emergency room care) In-Network	$50 co-pay
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 co-pay (not subject to ded.)
Tier 2 Drug	$65 co-pay (after ded.)
Tier 3 Drug	$90 co-pay (after ded.)
Annual Prescription Drug Deductible Individual	$200 ded./member
Annual Prescription Drug Deductible Family	$200 ded./member

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

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	$5,000
Annual Out-of-Pocket Maximum In-Network - Family	$10,000
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	0% coinsurance (after ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 co-pay (after ded.)
Tier 2 Drug	$50 co-pay (after ded.)
Tier 3 Drug	$90 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.

Summary of Benefits

EmblemHealth Prime Silver Premier	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$3600
Annual Plan Year Deductible In-Network - Family	$7,200
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	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	$35 (PCP)/$65 (Specialist) 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	$0 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

Summary of Benefits

EmblemHealth Select Care Silver Premier	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$3600
Annual Plan Year Deductible In-Network - Family	$7,200
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	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	$35 (PCP)/$65 (Specialist) 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	$0 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

Summary of Benefits

EmblemHealth Select Care Silver Value	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$6,700
Annual Plan Year Deductible In-Network - Family	$13,400
Annual Out-of-Pocket Maximum In-Network - Individual	$6,700
Annual Out-of-Pocket Maximum In-Network - Family	$13,400
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, 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	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.

Summary of Benefits

EmblemHealth Millennium Silver Value G	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$6,700
Annual Plan Year Deductible In-Network - Family	$13,400
Annual Out-of-Pocket Maximum In-Network - Individual	$6,700
Annual Out-of-Pocket Maximum In-Network - Family	$13,400
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, 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	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.

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	$6,000
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	$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 (not subject to 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/visit (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.

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 (not subject to ded.)
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 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

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 ded.
Annual Prescription Drug Deductible Family	$0 ded.

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

Summary of Benefits

Oscar Circle Silver 5000	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$5,000
Annual Plan Year Deductible In-Network - Family	$10,000
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	$40 co-pay (not subject to ded.)
Specialist Visit In-Network	$75 co-pay (not subject to ded.)
OB/GYN Preventive Care In-Network	$40 co-pay (not subject to ded.)
Diagnostic Lab Work In-Network	$75 co-pay (not subject to ded.)
Diagnostic X-Rays In-Network	$100 co-pay (not subject to ded.)
Radiology/Major Diagnostic Test In-network	$200 co-pay (not subject to ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$200 co-pay (after ded.)
Inpatient Hospital Stay	50% coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$200 co-pay (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$60 co-pay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	50% 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	50% coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$300 co-pay (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	50% coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	$90 co-pay (not subject to ded.)
Ambulance	50% coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$10 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.

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	$8,550
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	$30 co-pay (not subject to ded.)
Specialist Visit In-Network	$80 co-pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$20 co-pay (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 co-pay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	30% coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$80 co-pay (not subject to ded.)
Chiropractic Services In-Network	$80 co-pay (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 co-pay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 co-pay (not subject to ded.)
Tier 2 Drug	$65 co-pay (after ded.)
Tier 3 Drug	$90 co-pay (after ded.)
Annual Prescription Drug Deductible Individual	$150 ded./member
Annual Prescription Drug Deductible Family	$150 ded./member

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

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	$8,550
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	$50 co-pay
Specialist Visit In-Network	$100 co-pay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$40 co-pay
Diagnostic X-Rays In-Network	$150 co-pay
Radiology/Major Diagnostic Test In-network	$250 co-pay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$500 co-pay
Inpatient Hospital Stay	$1000 co-pay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$250 co-pay at Physicians Office, $350 co-pay at Hospital
Outpatient Rehabilitation/Therapy In-Network	$100 co-pay
Mental/Behavioral Inpatient Services In-Network	$1000 co-pay
Mental/Behavioral Outpatient Services In- Network	$100 co-pay
Chiropractic Services In-Network	$100 co-pay
Durable Medical Equipment	No Charge
Outpatient Surgery (Facility Fee) In-Network	$500 co-pay at Physicians Office, $700 co-pay at Hospital
Emergency/Urgent Care	
Emergency Room In-Network	$1350 co-pay
Urgent care (NON-emergency room care) In-Network	$100 co-pay
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$15 co-pay (not subject to ded.)
Tier 2 Drug	$65 co-pay (after ded.)
Tier 3 Drug	$90 co-pay (after ded.)
Annual Prescription Drug Deductible Individual	$150 ded./member
Annual Prescription Drug Deductible Family	$150 ded./member

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

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	$8,550
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	$25 co-pay (not subject to ded.)
Specialist Visit In-Network	$50 co-pay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$15 co-pay (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 co-pay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	50% coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$50 co-pay (not subject to ded.)
Chiropractic Services In-Network	$50 co-pay (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 co-pay (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 ded./member
Annual Prescription Drug Deductible Family	$200 ded./member

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

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	$8,550
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	$40 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	$25 co-pay (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 co-pay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	35% coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$70 co-pay (not subject to ded.)
Chiropractic Services In-Network	$70 co-pay (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 co-pay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$15 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 ded./member
Annual Prescription Drug Deductible Family	$200 ded./member

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

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	$8,550
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	$50 co-pay
Specialist Visit In-Network	$100 co-pay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$40 co-pay
Diagnostic X-Rays In-Network	$150 co-pay
Radiology/Major Diagnostic Test In-network	$250 co-pay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$500 co-pay
Inpatient Hospital Stay	$1000 co-pay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$250 co-pay Physician's Office, $350 co-pay Hospital Setting
Outpatient Rehabilitation/Therapy In-Network	$100 co-pay
Mental/Behavioral Inpatient Services In-Network	$1000 co-pay
Mental/Behavioral Outpatient Services In- Network	$100 co-pay
Chiropractic Services In-Network	$100 co-pay
Durable Medical Equipment	No Charge
Outpatient Surgery (Facility Fee) In-Network	$500 co-pay Physician's Office, $700 co-pay Hospital Setting
Emergency/Urgent Care	
Emergency Room In-Network	$1350 co-pay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	$100 co-pay (not subject to ded.)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 co-pay (not subject to ded.)
Tier 2 Drug	$65 co-pay (after ded.)
Tier 3 Drug	$95 co-pay (after ded.)
Annual Prescription Drug Deductible Individual	$150 ded./member
Annual Prescription Drug Deductible Family	$150 ded./member

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

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	$6,650
Annual Out-of-Pocket Maximum In-Network - Family	$13,300
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	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 co-pay (after ded.)
Tier 2 Drug	$50 co-pay (after ded.)
Tier 3 Drug	$90 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.

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.

Summary of Benefits

EmblemHealth Select Care Bronze Premier	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$5,300
Annual Plan Year Deductible In-Network - Family	$10,600
Annual Out-of-Pocket Maximum In-Network - Individual	$8,450
Annual Out-of-Pocket Maximum In-Network - Family	$16,900
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% Coisurance (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	$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.

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	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.

Summary of Benefits

EmblemHealth Millennium Bronze Premier G	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$5,300
Annual Plan Year Deductible In-Network - Family	$10,600
Annual Out-of-Pocket Maximum In-Network - Individual	$8,450
Annual Out-of-Pocket Maximum In-Network - Family	$16,900
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	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.

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	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.

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% coisurance (after ded.)
Inpatient Hospital Stay	50% coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% coisurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	50% coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	50% coisurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	50% coisurance (after ded.)
Chiropractic Services In-Network	50% coisurance (after ded.)
Durable Medical Equipment	50% coisurance (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.

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.

Summary of Benefits

Healthfirst Bronze 8150 Pro EPO	
Deductibles/Maxiums	
Annual Plan Year Deductible In-Network - Individual	$8,150
Annual Plan Year Deductible In-Network - Family	$16,300
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	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.

Summary of Benefits

Oscar Circle Bronze 4500	
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	$8,550
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	50% coinsurance (after ded.)
Specialist Visit In-Network	50% coinsurance (after ded.)
OB/GYN Preventive Care In-Network	50% coinsurance (after ded.)
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.

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	$7,000
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	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.

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	$7,000
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 (after ded.)
Specialist Visit In-Network	$75 co-pay (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 co-pay (after ded.)
Mental/Behavioral Inpatient Services In-Network	30% coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	$75 co-pay (after ded.)
Chiropractic Services In-Network	$75 co-pay (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.