



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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2022 Summary of Benefits

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

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

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2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

Oxford Metro Gold EPO 25/40 G

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

Oxford Liberty Gold EPO 30/60 G

Deductibles/Maximums

Annual Plan Year Deductible In-Network - Individual	\$1,250
Annual Plan Year Deductible In-Network - Family	\$2,500
Annual Out-of-Pocket Maximum In-Network - Individual	\$6,400
Annual Out-of-Pocket Maximum In-Network - Family	\$12,800
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A

Cost Sharing

Primary Care Visit In-Network	\$30 copay
Specialist Visit In-Network	\$60 copay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	No Charge
Diagnostic X-Rays In-Network	\$35 copay
Radiology/Major Diagnostic Test In-network	\$100 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Inpatient Hospital Stay	\$500 copay/day (\$2000 max) (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	\$60 copay/visit (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	\$500 copay/day (\$2000 max) (after ded.)
Mental/Behavioral Outpatient Services In- Network	\$60 copay (not subject to ded.)
Chiropractic Services In-Network	\$60 copay (after ded.)
Durable Medical Equipment	0% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	\$150 copay at Physician Office(after ded.), \$250 copay at Hospital (after ded.)

Emergency/Urgent Care

Emergency Room In-Network	\$500 copay (not subject to ded.)
Urgent care (NON-emergency room care) In-Network	\$75 copay (not subject to ded.)
Ambulance	No Charge

Prescription Drugs

Tier 1 Drug	\$10 copay (not subject to ded.)
Tier 2 Drug	\$50 copay (after ded.)
Tier 3 Drug	\$90 copay (after ded.)
Annual Prescription Drug Deductible Individual	\$200 Deductible/member
Annual Prescription Drug Deductible Family	\$200 Deductible/member

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

Oxford Liberty Silver EPO 25/50 G

Deductibles/Maximums

Annual Plan Year Deductible In-Network - Individual	\$4,500
Annual Plan Year Deductible In-Network - Family	\$9,000
Annual Out-of-Pocket Maximum In-Network - Individual	\$8,700
Annual Out-of-Pocket Maximum In-Network - Family	\$17,400
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A

Cost Sharing

Primary Care Visit In-Network	\$25 copay (not subject to ded.)
Specialist Visit In-Network	\$50 copay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	\$15 copay (not subject to ded.)
Diagnostic X-Rays In-Network	50% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	50% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Inpatient Hospital Stay	50% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	\$50 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	\$50 copay (not subject to ded.)
Chiropractic Services In-Network	\$50 copay (not subject to ded.)
Durable Medical Equipment	50% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded.)

Emergency/Urgent Care

Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	\$80 copay (not subject to ded.)
Ambulance	No Charge

Prescription Drugs

Tier 1 Drug	\$10 copay (not subject to ded.)
Tier 2 Drug	\$50 copay (after ded.)
Tier 3 Drug	\$90 copay (after ded.)
Annual Prescription Drug Deductible Individual	\$200 Deductible/member
Annual Prescription Drug Deductible Family	\$200 Deductible/member

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

EmblemHealth Prime Bronze HSA

Deductibles/Maximums

Annual Plan Year Deductible In-Network - Individual	\$6,300
Annual Plan Year Deductible In-Network - Family	\$12,600
Annual Out-of-Pocket Maximum In-Network - Individual	\$6,900
Annual Out-of-Pocket Maximum In-Network - Family	\$13,800
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A

Cost Sharing

Primary Care Visit In-Network	50% Coinsurance (after ded.)
Specialist Visit In-Network	50% Coinsurance (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	50% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	50% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	50% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Inpatient Hospital Stay	50% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	50% Coinsurance (after ded.)
Chiropractic Services In-Network	50% Coinsurance (after ded.)
Durable Medical Equipment	50% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded.)

Emergency/Urgent Care

Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	\$100 Co-Pay (after ded.)
Ambulance	50% Coinsurance (after ded.)

Prescription Drugs

Tier 1 Drug	\$15 Co-Pay (after ded.)
Tier 2 Drug	\$65 Co-Pay (after ded.)
Tier 3 Drug	\$80 Co-Pay (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

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

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



2022 Summary of Benefits

Oxford Liberty Bronze HSA 5750

Deductibles/Maximums

Annual Plan Year Deductible In-Network - Individual	\$5,750
Annual Plan Year Deductible In-Network - Family	\$11,500
Annual Out-of-Pocket Maximum In-Network - Individual	\$7,050
Annual Out-of-Pocket Maximum In-Network - Family	\$14,100
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A

Cost Sharing

Primary Care Visit In-Network	\$25 copay (after ded.)
Specialist Visit In-Network	\$75 copay (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	30% Coinsurance (after ded.)
Diagnostic X-Rays In-Network	30% Coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	30% Coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded.)
Inpatient Hospital Stay	30% Coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	\$75 copay (after ded.)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network	\$75 copay (after ded.)
Chiropractic Services In-Network	\$75 copay (after ded.)
Durable Medical Equipment	30% Coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	30% Coinsurance (after ded.)

Emergency/Urgent Care

Emergency Room In-Network	50% Coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network	30% Coinsurance (after ded.)
Ambulance	30% Coinsurance (after ded.)

Prescription Drugs

Tier 1 Drug	30% Coinsurance (after ded.)
Tier 2 Drug	30% Coinsurance (after ded.)
Tier 3 Drug	30% Coinsurance (after ded.)
Annual Prescription Drug Deductible Individual	Combined w/Medical
Annual Prescription Drug Deductible Family	Combined w/Medical

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