HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Bridge Platinum PPO - Renewal Only	EmblemHealth Prime Platinum Premier
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$0	$0
Annual Plan Year Deductible In-Network - Family	$0	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$2,500	$2,500
Annual Out-of-Pocket Maximum In-Network - Family	$5,000	$5,000
Annual Plan Year Deductible Out-of-Network - Individual	$3,000	N/A
Annual Plan Year Deductible Out-of-Network - Family	$6,000	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	$5,500	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	$11,000	N/A
Cost Sharing		
Primary Care Visit In-Network	First 3 visits, free. Thereafter, $15 copay (not subject to ded)	First 3 visits, No Charge. Thereafter, $15 copay (not subject to ded)
Specialist Visit In-Network	$35 copay (not subject to ded)	$35 copay (not subject to ded)
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	$15 (PCP)/$35 (Specialist) copay	$15 (PCP)/$35 (Specialist) copay
Diagnostic X-Rays In-Network	$15 (PCP)/$35 (Specialist) copay	$15 (PCP)/$35 (Specialist) copay
Radiology/Major Diagnostic Test In-network	$35 copay	$35 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$200 copay	$250 copay
Inpatient Hospital Stay	20% Coinsurance, per admission	20% Coinsurance, per admission
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$200 copay	$250 copay
Outpatient Rehabilitation/Therapy In-Network	$15 (PCP)/$35(Specialist) copay	$15 (PCP)/$35 (Specialist) copay
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance, per admission	20% Coinsurance,per admission
Mental/Behavioral Outpatient Services In- Network	First 3 visits, free. Thereafter, $15 copay (not subject to ded)	First 3 visits, No Charge. Thereafter, $15 copay
Chiropractic Services In-Network	$35 copay (not subject to ded)	$35 copay (not subject to ded)
Durable Medical Equipment	10% Coinsurance	10% Coinsurance
Outpatient Surgery (Facility Fee) In-Network	$200 copay	$250 copay
Emergency/Urgent Care		
Emergency Room In-Network	20% Coinsurance	$400 copay
Urgent care (NON-emergency room care) In-Network	$100 copay	$100 copay
Ambulance	20% Coinsurance	$250 copay
Prescription Drugs		
Tier 1 Drug	$0 copay	$0 copay
Tier 2 Drug	$30 copay	$30 copay
Tier 3 Drug	$80 copay	$65 copay
Annual Prescription Drug Deductible Individual	$0 Deductible	$0 Deductible
Annual Prescription Drug Deductible Family	$0 Deductible	$0 Deductible

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Healthfirst Platinum Pro EPO	Oxford Liberty Platinum EPO
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$0	$500
Annual Plan Year Deductible In-Network - Family	$0	$1,000
Annual Out-of-Pocket Maximum In-Network - Individual	$2,000	$2,450
Annual Out-of-Pocket Maximum In-Network - Family	$4,000	$4,900
Annual Plan Year Deductible Out-of-Network - Individual	N/A	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A	N/A
Cost Sharing		
Primary Care Visit In-Network	$20 copay	$5 copay/$25 copay (not subject to ded)
Specialist Visit In-Network	$35 copay	$35 copay/$70 copay (not subject to ded)
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	$20 (PCP)/$35 (Specialist) copay (not subject to ded)	50% Coinsurance (after ded)
Diagnostic X-Rays In-Network	$20 (PCP)/$35 (Specialist) copay (not subject to ded)	0% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	$35 copay	0% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$100 copay	0% Coinsurance (after ded)
Inpatient Hospital Stay	$500 copay/admission	0% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$100 copay	0% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$35 copay	$70 copay (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	$500 copay/admission	0% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$20 copay	$25 copay (not subject to ded)
Chiropractic Services In-Network	$35 copay	$35 copay (not subject to ded)
Durable Medical Equipment	10% Coinsurance	0% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	$200 copay	0% Coinsurance (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	$250 copay	$250 copay (not subject to ded)
Urgent care (NON-emergency room care) In-Network	$50 copay	75$ copay (not subject to ded)
Ambulance	$150 copay	No Charge
Prescription Drugs		
Tier 1 Drug	$10 copay	$10 copay (not subject to ded)
Tier 2 Drug	$30 copay	$50 copay (after ded)
Tier 3 Drug	$60 copay	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	$0 Deductible	$200 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$0 Deductible	$200 Deductible/member (N/A Tier 1)

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Bridge Gold PPO - Renewal Only	EmblemHealth Prime Gold Premier
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$1,500	$500
Annual Plan Year Deductible In-Network - Family	$3,000	$1,000
Annual Out-of-Pocket Maximum In-Network - Individual	$6,200	$7,500
Annual Out-of-Pocket Maximum In-Network - Family	$12,400	$15,000
Annual Plan Year Deductible Out-of-Network - Individual	$3,800	N/A
Annual Plan Year Deductible Out-of-Network - Family	$7,600	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	$8,000	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	$16,000	N/A
Cost Sharing		
Primary Care Visit In-Network	First 3 visits, free. Thereafter, $25 copay (not subject to ded)	First 3 visits, free. Thereafter, $25 copay (not subject to ded)
Specialist Visit In-Network	$40 copay (not subject to ded)	$50 copay (not subject to ded)
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	$25 (PCP)/$40 (Specialist) copay (after ded)	$25 (PCP)/$50 (Specialist) copay (not subject to ded)
Diagnostic X-Rays In-Network	$25 (PCP)/$40 (Specialist) copay (after ded)	$25 (PCP)/$50 (Specialist) copay (after ded)
Radiology/Major Diagnostic Test In-network	$40 copay (after ded)	$50 copay after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$300 copay (after ded)	$350 copay (after ded)
Inpatient Hospital Stay	30% Coinsurance, per admission (after ded)	30% Coinsurance, per admission (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$300 copay (after ded)	$350 copay (after ded)
Outpatient Rehabilitation/Therapy In-Network	$25 (PCP)/$40 (Specialist) copay (after ded)	$25 (PCP)/$50 (Specialist) copay (after ded)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance, per admission (after ded)	30% Coinsurance, per admission (after ded)
Mental/Behavioral Outpatient Services In- Network	First 3 visits, free. Thereafter, $25 copay (not subject to ded)	First 3 visits, free. Thereafter, $25 copay (not subject to ded)
Chiropractic Services In-Network	$40 copay (not subject to ded)	$50 copay (not subject to ded)
Durable Medical Equipment	20% Coinsurance (after ded)	20% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	$300 copay (after ded)	$350 copay (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	30% Coinsurance (after ded)	$800 copay (after ded)
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded)	$100 copay (after ded)
Ambulance	30% Coinsurance (after ded)	$350 copay (after ded)
Prescription Drugs		
Tier 1 Drug	$0 copay	$0 copay
Tier 2 Drug	$45 copay	$40 copay
Tier 3 Drug	$100 copay	$80 copay
Annual Prescription Drug Deductible Individual	$0 Deductible	$0 Deductible
Annual Prescription Drug Deductible Family	$0 Deductible	$0 Deductible

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Bridge Gold Virtual Renewal Only	Healthfirst Gold 1350 Pro Plus EPO
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$750	$1,350
Annual Plan Year Deductible In-Network - Family	$1,500	$2,700
Annual Out-of-Pocket Maximum In-Network - Individual	$8,000	$7,900
Annual Out-of-Pocket Maximum In-Network - Family	$16,000	$15,800
Annual Plan Year Deductible Out-of-Network - Individual	N/A	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A	N/A
Cost Sharing		
Primary Care Visit In-Network	$40 copay (not subject to ded)	$25 copay
Specialist Visit In-Network	$60 copay (not subject to ded)	$70 copay
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	$0 (PCP)/$60 (Specialist) copay (not subject to ded)	$25 (PCP)/ $70 (Specialist) copay
Diagnostic X-Rays In-Network	$40 (PCP)/$60 (Specialist) copay (after ded)	$25 (PCP)/ $70 (Specialist) copay
Radiology/Major Diagnostic Test In-network	$60 copay (after ded)	$70 copay/visit
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 copay (after ded)	20% coinsurance after deductible
Inpatient Hospital Stay	30% Coinsurance, per admission (after ded)	20% coinsurance after deductible
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 copay (after ded)	20% coinsurance after deductible
Outpatient Rehabilitation/Therapy In-Network	$40 (PCP)/$60 (Specialist) copay (after ded)	$70 copay (after deductible)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance, per admission (after ded)	20% coinsurance after deductible
Mental/Behavioral Outpatient Services In- Network	$40 copay (not subject to ded)	$25 copay
Chiropractic Services In-Network	$60 copay (not subject to ded)	$70 copay
Durable Medical Equipment	20% Coinsurance (after ded)	20% coinsurance after deductible
Outpatient Surgery (Facility Fee) In-Network	$350 copay (after ded)	20% coinsurance after deductible
Emergency/Urgent Care		
Emergency Room In-Network	40% Coinsurance (after ded)	$600 copay after deductible
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded)	$60 copay
Ambulance	$350 copay (after ded)	$150 copay
Prescription Drugs		
Tier 1 Drug	$0 copay (not subject to ded)	$20 copay
Tier 2 Drug	$40 copay (after ded)	$60 copay
Tier 3 Drug	$80 copay (after ded)	$110 copay
Annual Prescription Drug Deductible Individual	Combined w/ Medical	$0 Deductible
Annual Prescription Drug Deductible Family	Combined w/ Medical	$0 Deductible

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

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

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Liberty Gold EPO 30/60	Oxford Liberty Gold EPO 30/60 G
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$2,000	$1,250
Annual Plan Year Deductible In-Network - Family	$4,000	$2,500
Annual Out-of-Pocket Maximum In-Network - Individual	$8,000	$6,650
Annual Out-of-Pocket Maximum In-Network - Family	$16,000	$13,300
Annual Plan Year Deductible Out-of-Network - Individual	N/A	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A	N/A
Cost Sharing		
Primary Care Visit In-Network	$30 copay (not subject to ded)	$30 copay
Specialist Visit In-Network	$60 copay (not subject to ded)	$60 copay
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	No Charge (Designated Diagnostic Provider) 50% Coinsurance after ded. (Non-Designated Diagnostic Provider)	No Charge (Designated Dianostic Provider) 50% coinsurance after ded. (Non-Desginated Diagnostic Provider)
Diagnostic X-Rays In-Network	30% Coinsurance (after ded)	$35 copay (after ded)
Radiology/Major Diagnostic Test In-network	30% Coinsurance (after ded)	$35 copay after ded. (Radiology) $100 copay (Major Radiology)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded)	0% Coinsurance (after ded)
Inpatient Hospital Stay	30% Coinsurance (after ded)	$500 copay/day ($2000 max) (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded)	0% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$30 copay (not subject to ded)	$60 copay/visit
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded)	$500 copay/day ($2000 max) (after ded)
Mental/Behavioral Outpatient Services In- Network	$30 copay (not subject to ded)	$30 copay per visit; No Charge after ded. (partial hospitalization)
Chiropractic Services In-Network	$60 copay (not subject to ded)	$60 copay
Durable Medical Equipment	30% Coinsurance (after ded)	0% Coinsurance (after ded) (Precertification required for items over $500)
Outpatient Surgery (Facility Fee) In-Network	30% Coinsurance (after ded)	$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)	$500 copay (not subject to ded)
Urgent care (NON-emergency room care) In-Network	$75 copay (not subject to ded)	$75 copay (not subjet to ded)
Ambulance	No Charge	No Charge
Prescription Drugs		
Tier 1 Drug	$10 copay (not subject to ded)	$10 copay (not subject to ded)
Tier 2 Drug	$50 copay (after ded)	$50 copay (after ded)
Tier 3 Drug	$90 copay (after ded)	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member (N/A Tier 1)	$200 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)	$200 Deductible/member (N/A Tier 1)

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Liberty Gold EPO 25/50 ZD	Oxford Liberty Gold HSA 1500 M
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$0	$1,500
Annual Plan Year Deductible In-Network - Family	$0	$3,000
Annual Out-of-Pocket Maximum In-Network - Individual	$6,250	$5,750
Annual Out-of-Pocket Maximum In-Network - Family	$12,500	$11,500
Annual Plan Year Deductible Out-of-Network - Individual	N/A	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A	N/A
Cost Sharing		
Primary Care Visit In-Network	$25 copay	10% Coinsurance (after ded)
Specialist Visit In-Network	$50 copay	10% Coinsurance (after ded)
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	No Charge (Designated Diagnostic Provider $60 copay (Non-Designated Diagnostic Provider)	10% Coinsurance (after ded)
Diagnostic X-Rays In-Network	$50 copay	10% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	$50 copay (Radiology) $150 copay (Major Diagnostic)	10% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay per visit	10% Coinsurance (after ded)
Inpatient Hospital Stay	$500 copay per admission	10% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$150 copay at Physicians Office, $500 copay at Hospital	10% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$50 copay	10% Coinsurance (after ded)
Mental/Behavioral Inpatient Services In-Network	$500 copay	10% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$25 copay	10% Coinsurance (after ded)
Chiropractic Services In-Network	$50 copay	10% Coinsurance (after ded)
Durable Medical Equipment	No Charge (Precertification required for items over $500)	10% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	$150 copay	10% Coinsurance (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	$750 copay	50% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$50 copay	10% Coinsurance (after ded)
Ambulance	No Charge	10% Coinsurance (after ded)
Prescription Drugs		
Tier 1 Drug	$10 copay (not subject to ded)	$10 copay (after ded)
Tier 2 Drug	$50 copay (after ded)	$50 copay (after ded)
Tier 3 Drug	$90 copay (after ded)	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member (N/A Tier 1)	Combined w/Medical
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)	Combined w/Medical

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Prime Silver Premier	EmblemHealth Prime Silver HSA
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$4,800	$3,500
Annual Plan Year Deductible In-Network - Family	$9,600	$7,000
Annual Out-of-Pocket Maximum In-Network - Individual	$8,800	$7,000
Annual Out-of-Pocket Maximum In-Network - Family	$17,600	$14,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A	N/A
Cost Sharing		
Primary Care Visit In-Network	First visit, free. Thereafter, $35 Co-Pay (not subject to ded)	$30 Co-Pay (after ded)
Specialist Visit In-Network	$75 Co-Pay (not subject to ded)	$50 Co-Pay (after ded)
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	$35 (PCP)/$75 (Specialist) Co-Pay (not subject to ded)	$30 (PCP)/$50 (Specialist) Co-Pay (after ded)
Diagnostic X-Rays In-Network	$35 (PCP)/$75 (Specialist) Co-Pay (after ded)	$30 (PCP)/$50 (Specialist) Co-Pay (after ded)
Radiology/Major Diagnostic Test In-network	$75 Co-Pay (after ded)	$50 Co-Pay (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$450 Co-Pay (after ded)	$450 Co-Pay (after ded)
Inpatient Hospital Stay	40% Coinsurance, per admission (after ded)	40% Coinsurance, per admission (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$450 Co-Pay (after ded)	$450 Co-Pay (after ded)
Outpatient Rehabilitation/Therapy In-Network	$35 (PCP)/$75 (Specialist) Co-Pay (after ded)	$30 (PCP)/$50 (Specialist) Co-Pay (after ded)
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance, per admission (after ded)	40% Coinsurance, per admission (after ded)
Mental/Behavioral Outpatient Services In- Network	First visit, free. Thereafter, $35 Co-Pay (not subject to ded)	$30 Co-Pay (after ded)
Chiropractic Services In-Network	$75 Co-Pay (not subject to ded)	$50 Co-Pay (after ded)
Durable Medical Equipment	30% Coinsurance (after ded)	30% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	$450 Co-Pay (after ded)	$450 Co-Pay (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	$1000 Co-Pay (after ded)	40% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$100 Co-Pay (after ded)	$100 Co-Pay (after ded)
Ambulance	$450 Co-Pay (after ded)	$450 Co-Pay (after ded)
Prescription Drugs		
Tier 1 Drug	$0 Co-Pay	$15 Co-Pay (after ded)
Tier 2 Drug	$40 Co-Pay	$45 Co-Pay (after ded)
Tier 3 Drug	$80 Co-Pay	$80 Co-Pay (after ded)
Annual Prescription Drug Deductible Individual	$0 Deductible	Combined w/ Medical
Annual Prescription Drug Deductible Family	$0 Deductible	Combined w/ Medical

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Healthfirst Silver Pro EPO	Healthfirst Silver 45/75/4300 Pro EPO
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$4,300	$4,300
Annual Plan Year Deductible In-Network - Family	$8,600	$8,600
Annual Out-of-Pocket Maximum In-Network - Individual	$8,150	$8,150
Annual Out-of-Pocket Maximum In-Network - Family	$16,300	$16,300
Annual Plan Year Deductible Out-of-Network - Individual	N/A	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A	N/A
Cost Sharing		
Primary Care Visit In-Network	$35 copay (not subject to ded)	$45 copay (not subject to ded)
Specialist Visit In-Network	$70 copay (not subject to ded)	$75 copay (not subject to ded)
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	$35 (PCP)/ $70 (Specialist) copay after ded.	$45 (PCP)/ $75 (Specialist) copay (not subject to ded)
Diagnostic X-Rays In-Network	$35 (PCP)/ $70 (Specialist) copay after ded.	$45 (PCP)/ $75 (Specialist) copay (not subject to ded)
Radiology/Major Diagnostic Test In-network	$70 copay (after ded)	$75 copay (not subject to ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$200 copay (after ded)	$200 copay (after ded)
Inpatient Hospital Stay	40% Coinsurance (after ded)	40% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$200 copay (after ded)	$200 copay (after ded)
Outpatient Rehabilitation/Therapy In-Network	$70 copay (not subject to ded)	$75 copay (after ded)
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance (after ded)	40% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$35 copay (not subject to ded)	$45 copay (not subject to ded)
Chiropractic Services In-Network	$70 copay (not subject to ded)	$75 copay (not subject to ded)
Durable Medical Equipment	40% Coinsurance (after ded)	40% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	40% Coinsurance (after ded)	40% Coinsurance (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	$600 copay (after ded)	$600 copay (after ded)
Urgent care (NON-emergency room care) In-Network	$70 copay (not subject to ded)	$75 copay (not subject to ded)
Ambulance	$300 copay (after ded)	$300 copay (after ded)
Prescription Drugs		
Tier 1 Drug	$20 copay	$20 copay
Tier 2 Drug	$60 copay	$60 copay
Tier 3 Drug	$110 copay	$110 copay
Annual Prescription Drug Deductible Individual	$0 Deductible	$0 Deductible
Annual Prescription Drug Deductible Family	$0 Deductible	$0 Deductible

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Metro Silver EPO 30/80 G	Oxford Metro Silver EPO 50/100 ZD
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$3,750	$0
Annual Plan Year Deductible In-Network - Family	$7,500	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$9,100	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$18,200	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A	N/A
Cost Sharing		
Primary Care Visit In-Network	$30 copay (not subject to ded)	$50 copay
Specialist Visit In-Network	$80 copay (not subject to ded)	$100 copay
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	50% Coinsurance (after ded)	$60 copay
Diagnostic X-Rays In-Network	40% Coinsurance (after ded)	$150 copay
Radiology/Major Diagnostic Test In-network	40% Coinsurance (after ded)	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	40% Coinsurance (after ded)	$1400 copay
Inpatient Hospital Stay	40% Coinsurance (after ded)	$2800 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	40% Coinsurance (after ded)	$250 copay at Physicians Office, $350 copay at Hospital
Outpatient Rehabilitation/Therapy In-Network	$80 copay (not subject to ded)	$100 copay
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance (after ded)	$2800 copay
Mental/Behavioral Outpatient Services In- Network	$30 copay (not subject to ded)	$50 copay
Chiropractic Services In-Network	$80 copay (not subject to ded)	$100 copay
Durable Medical Equipment	40% Coinsurance (after ded)	No Charge
Outpatient Surgery (Facility Fee) In-Network	40% Coinsurance (after ded)	$500 copay at Physicians Office, $700 copay at Hospital
Emergency/Urgent Care		
Emergency Room In-Network	50% Coinsurance (after ded)	$1400 copay
Urgent care (NON-emergency room care) In-Network	$80 copay (not subject to ded)	$100 copay
Ambulance	No Charge	No Charge
Prescription Drugs		
Tier 1 Drug	$10 copay (not subject to ded)	$10 copay (not subject to ded)
Tier 2 Drug	$65 copay (after ded)	$65 copay (after ded)
Tier 3 Drug	$95 copay (after ded)	$95 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member	$200 Deductible/member
Annual Prescription Drug Deductible Family	$200 Deductible/member	$200 Deductible/member

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Liberty Silver EPO 30/60 G	Oxford Liberty Silver EPO 40/80
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$4,500	$3,250
Annual Plan Year Deductible In-Network - Family	$9,000	$6,500
Annual Out-of-Pocket Maximum In-Network - Individual	$9,100	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$18,200	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A	N/A
Cost Sharing		
Primary Care Visit In-Network	$30 copay (not subject to ded)	$40 copay (not subject to ded)
Specialist Visit In-Network	$60 copay (not subject to ded)	$80 copay (not subject to ded)
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Diagnostic X-Rays In-Network	50% Coinsurance (after ded)	40% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	50% Coinsurance (after ded)	40% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded)	40% Coinsurance (after ded)
Inpatient Hospital Stay	50% Coinsurance (after ded)	40% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded)	40% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$60 copay (not subject to ded)	$80 copay (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance (after ded)	40% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$30 copay (not subject to ded)	$40 copay (not subject to ded)
Chiropractic Services In-Network	$60 copay (not subject to ded)	$80 copay (not subject to ded)
Durable Medical Equipment	50% Coinsurance (after ded)	40% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded)	40% Coinsurance (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$80 copay (not subject to ded)	$75 copay (not subject to ded)
Ambulance	No Charge	No Charge
Prescription Drugs		
Tier 1 Drug	$10 copay (not subject to ded)	$10 copay (not subject to ded)
Tier 2 Drug	$50 copay (after ded)	$50 copay (after ded)
Tier 3 Drug	$90 copay (after ded)	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member	$200 Deductible/member
Annual Prescription Drug Deductible Family	$200 Deductible/member	$200 Deductible/member

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Liberty Silver EPO 50/100 ZD	Oxford Liberty Silver HSA 4000 M
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$0	$4,000
Annual Plan Year Deductible In-Network - Family	$0	$8,000
Annual Out-of-Pocket Maximum In-Network - Individual	$9,100	$7,350
Annual Out-of-Pocket Maximum In-Network - Family	$18,200	$14,700
Annual Plan Year Deductible Out-of-Network - Individual	N/A	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A	N/A
Cost Sharing		
Primary Care Visit In-Network	$50 copay	20% Coinsurance (after ded)
Specialist Visit In-Network	$100 copay	20% Coinsurance (after ded)
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	$60 copay	20% Coinsurance (after ded)
Diagnostic X-Rays In-Network	$150 copay	20% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	$250 copay	20% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$1400 copay	20% Coinsurance (after ded)
Inpatient Hospital Stay	$2800 copay	20% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay Physician's Office, $350 copay Hospital Setting	20% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$100 copay	20% Coinsurance (after ded)
Mental/Behavioral Inpatient Services In-Network	$2800 copay	20% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$50 copay	20% Coinsurance (after ded)
Chiropractic Services In-Network	$100 copay	20% Coinsurance (after ded)
Durable Medical Equipment	No Charge	20% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	$500 copay Physician's Office, $700 copay Hospital Setting	20% Coinsurance (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	$1400 copay	50% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$100 copay	20% Coinsurance (after ded)
Ambulance	No Charge	20% Coinsurance (after ded)
Prescription Drugs		
Tier 1 Drug	$10 copay (not subject to ded)	$10 copay (after ded)
Tier 2 Drug	$65 copay (after ded)	$50 copay (after ded)
Tier 3 Drug	$95 copay (after ded)	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member	Combined w/Medical
Annual Prescription Drug Deductible Family	$200 Deductible/member	Combined w/Medical

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Prime Bronze HSA	EmblemHealth Prime Bronze Premier
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$6,750	$6,300
Annual Plan Year Deductible In-Network - Family	$13,500	$12,600
Annual Out-of-Pocket Maximum In-Network - Individual	$7,500	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$15,000	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A	N/A
Cost Sharing		
Primary Care Visit In-Network	50% Coinsurance (after ded)	First visit, free. Thereafter, 50% Coinsurance (after ded)
Specialist Visit In-Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Diagnostic X-Rays In-Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Inpatient Hospital Stay	50% Coinsurance, per admission (after ded)	50% Coinsurance, per admission (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance, per admission (after ded)	50% Coinsurance, per admission (after ded)
Mental/Behavioral Outpatient Services In- Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Chiropractic Services In-Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Durable Medical Equipment	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded)	50% Coinsurance (after ded)
Ambulance	50% Coinsurance (after ded)	50% Coinsurance (after ded)
Prescription Drugs		
Tier 1 Drug	$15 copay (after ded)	$50 copay (not subject to ded)
Tier 2 Drug	$65 copay (after ded)	50% Coinsurance (after ded)
Tier 3 Drug	$100 copay (after ded)	50% Coinsurance (after ded)
Annual Prescription Drug Deductible Individual	Combined w/ Medical	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical	Combined w/ Medical

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Healthfirst Bronze 6850 Pro EPO HSA	Oxford Metro Bronze HSA 7000 G
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$6,850	$7,000
Annual Plan Year Deductible In-Network - Family	$13,700	$14,000
Annual Out-of-Pocket Maximum In-Network - Individual	$6,850	$7,000
Annual Out-of-Pocket Maximum In-Network - Family	$13,700	$14,000
Annual Plan Year Deductible Out-of-Network - Individual	N/A	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A	N/A
Cost Sharing		
Primary Care Visit In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Specialist Visit In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
OB/GYN Preventive Care In-Network	No Charge	No Charge
Diagnostic Lab Work In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Diagnostic X-Rays In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Inpatient Hospital Stay	0% Coinsurance (after ded)	0% coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Mental/Behavioral Inpatient Services In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Chiropractic Services In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Durable Medical Equipment	0% Coinsurance (after ded)	0% coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	0% Coinsurance (after ded)	0% coinsurance (after ded)
Ambulance	0% Coinsurance (after ded)	0% coinsurance (after ded)
Prescription Drugs		
Tier 1 Drug	0% Coinsurance (after ded)	0% coinsurance (after ded)
Tier 2 Drug	0% Coinsurance (after ded)	0% coinsurance (after ded)
Tier 3 Drug	0% Coinsurance (after ded)	0% coinsurance (after ded)
Annual Prescription Drug Deductible Individual	Combined w/ Medical	Combined w/Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical	Combined w/Medical

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Liberty Bronze HSA 5750
Deductible/Out-of-Pocket Max	
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	$7,350
Annual Out-of-Pocket Maximum In-Network - Family	$14,700
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	$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	$25 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.