HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Prime Platinum Premier
Deductible/Out-of-Pocket Max	
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	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 copay (not subject to ded)
Specialist Visit In-Network	$35 copay (not subject to ded)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$15 (PCP)/$35 (Specialist) copay
Diagnostic X-Rays In-Network	$15 (PCP)/$35 (Specialist) copay
Radiology/Major Diagnostic Test In-network	$35 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay
Inpatient Hospital Stay	20% Coinsurance, per admission
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay
Outpatient Rehabilitation/Therapy In-Network	$15 (PCP)/$35 (Specialist) copay
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance, per admission
Mental/Behavioral Outpatient Services In- Network	First 3 visits, No Charge. Thereafter, $15 copay
Chiropractic Services In-Network	$35 copay (not subject to ded)
Durable Medical Equipment	10% Coinsurance
Outpatient Surgery (Facility Fee) In-Network	$250 copay
Emergency/Urgent Care	
Emergency Room In-Network	$400 copay
Urgent care (NON-emergency room care) In-Network	$100 copay
Ambulance	$250 copay
Prescription Drugs	
Tier 1 Drug	$0 copay
Tier 2 Drug	$30 copay
Tier 3 Drug	$65 copay
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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Empire Platinum EPO 5/25
Deductible/Out-of-Pocket Max	**In-Network**
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$3,500
Annual Out-of-Pocket Maximum In-Network - Family	$7,000
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	$5 copay
Specialist Visit In-Network	$25 copay
OB/GYN Preventive Care In-Network	No charge
Diagnostic Lab Work In-Network	No charge
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	No charge
Inpatient Hospital Stay	$400 copay/admission
Outpatient Surgery (Physician/Surgeon Fee) In-Network	No charge
Outpatient Rehabilitation/Therapy In-Network	$5 copay
Mental/Behavioral Inpatient Services In-Network	$400 copay/admission
Mental/Behavioral Outpatient Services In- Network	$5 copay
Chiropractic Services In-Network	$25 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$300 copay
Emergency/Urgent Care	
Emergency Room In-Network	$300 copay
Urgent care (NON-emergency room care) In-Network	$75 copay
Ambulance	$300 copay
Prescription Drugs	
Tier 1 Drug	$10 copay
Tier 2 Drug	$35 copay
Tier 3 Drug	$70 copay
Annual Prescription Drug Deductible Individual	$100 Deductible does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$200 Deductible does not apply to Tier 1 drugs

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Empire Connection Platinum EPO 20/40
Deductible/Out-of-Pocket Max	**In-Network**
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$2,750
Annual Out-of-Pocket Maximum In-Network - Family	$5,500
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$20 copay
Specialist Visit In-Network	$40 copay
OB/GYN Preventive Care In-Network	No charge
Diagnostic Lab Work In-Network	No charge
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	No charge
Inpatient Hospital Stay	$500 copay/admission
Outpatient Surgery (Physician/Surgeon Fee) In-Network	No charge
Outpatient Rehabilitation/Therapy In-Network	$20 copay
Mental/Behavioral Inpatient Services In-Network	$500 copay/admission
Mental/Behavioral Outpatient Services In- Network	$20 copay per visit
Chiropractic Services In-Network	$40 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$500 copay
Emergency/Urgent Care	
Emergency Room In-Network	$300 copay
Urgent care (NON-emergency room care) In-Network	$50 copay
Ambulance	$300 copay
Prescription Drugs	
Tier 1 Drug	$10 copay
Tier 2 Drug	$35 copay
Tier 3 Drug	$70 copay
Annual Prescription Drug Deductible Individual	$100 Deductible does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$200 Deductible does not apply to Tier 1 drugs

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 Platinum EPO
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$500
Annual Plan Year Deductible In-Network - Family	$1,000
Annual Out-of-Pocket Maximum In-Network - Individual	$2,450
Annual Out-of-Pocket Maximum In-Network - Family	$4,900
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$5 copay/$25 copay (not subject to ded)
Specialist Visit In-Network	$35 copay/$70 copay (not subject to ded)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	50% 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	$25 copay (not subject to ded)
Chiropractic Services In-Network	$35 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 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 (N/A Tier 1)
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Bridge Gold PPO - Renewal Only
Deductible/Out-of-Pocket Max	
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	$6,200
Annual Out-of-Pocket Maximum In-Network - Family	$12,400
Annual Plan Year Deductible Out-of-Network - Individual	$3,800
Annual Plan Year Deductible Out-of-Network - Family	$7,600
Annual Out-of-Pocket Maximum Out-of-Network - Individual	$8,000
Annual Out-of-Pocket Maximum Out-of-Network - Family	$16,000
Cost Sharing	
Primary Care Visit In-Network	First 3 visits, free. Thereafter, $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	$25 (PCP)/$40 (Specialist) copay (after ded)
Diagnostic X-Rays In-Network	$25 (PCP)/$40 (Specialist) copay (after ded)
Radiology/Major Diagnostic Test In-network	$40 copay (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$300 copay (after ded)
Inpatient Hospital Stay	30% Coinsurance, per admission (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$300 copay (after ded)
Outpatient Rehabilitation/Therapy In-Network	$25 (PCP)/$40 (Specialist) copay (after ded)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance, per admission (after ded)
Mental/Behavioral Outpatient Services In- Network	First 3 visits, free. Thereafter, $25 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	$300 copay (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	30% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded)
Ambulance	30% Coinsurance (after ded)
Prescription Drugs	
Tier 1 Drug	$0 copay
Tier 2 Drug	$45 copay
Tier 3 Drug	$100 copay
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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Prime Gold Premier
Deductible/Out-of-Pocket Max	
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	$7,500
Annual Out-of-Pocket Maximum In-Network - Family	$15,000
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 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	$25 (PCP)/$50 (Specialist) copay (not subject to ded)
Diagnostic X-Rays In-Network	$25 (PCP)/$50 (Specialist) copay (after ded)
Radiology/Major Diagnostic Test In-network	$50 copay after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 copay (after ded)
Inpatient Hospital Stay	30% Coinsurance, per admission (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 copay (after ded)
Outpatient Rehabilitation/Therapy In-Network	$25 (PCP)/$50 (Specialist) copay (after ded)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance, per admission (after ded)
Mental/Behavioral Outpatient Services In- Network	First 3 visits, free. Thereafter, $25 copay (not subject to ded)
Chiropractic Services In-Network	$50 copay (not subject to ded)
Durable Medical Equipment	20% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	$350 copay (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	$800 copay (after ded)
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded)
Ambulance	$350 copay (after ded)
Prescription Drugs	
Tier 1 Drug	$0 copay
Tier 2 Drug	$40 copay
Tier 3 Drug	$80 copay
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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Bridge Gold Virtual Renewal Only
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$750
Annual Plan Year Deductible In-Network - Family	$1,500
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	$40 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	$0 (PCP)/$60 (Specialist) copay (not subject to ded)
Diagnostic X-Rays In-Network	$40 (PCP)/$60 (Specialist) copay (after ded)
Radiology/Major Diagnostic Test In-network	$60 copay (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$350 copay (after ded)
Inpatient Hospital Stay	30% Coinsurance, per admission (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$350 copay (after ded)
Outpatient Rehabilitation/Therapy In-Network	$40 (PCP)/$60 (Specialist) copay (after ded)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance, per admission (after ded)
Mental/Behavioral Outpatient Services In- Network	$40 copay (not subject to ded)
Chiropractic Services In-Network	$60 copay (not subject to ded)
Durable Medical Equipment	20% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	$350 copay (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	40% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded)
Ambulance	$350 copay (after ded)
Prescription Drugs	
Tier 1 Drug	$0 copay (not subject to ded)
Tier 2 Drug	$40 copay (after ded)
Tier 3 Drug	$80 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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Empire Blue Access Gold EPO 30/55
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$1,000
Annual Plan Year Deductible In-Network - Family	$2,000
Annual Out-of-Pocket Maximum In-Network - Individual	$6,750
Annual Out-of-Pocket Maximum In-Network - Family	$13,500
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$30 copay (ded does not apply)
Specialist Visit In-Network	$55 copay (ded does not apply)
OB/GYN Preventive Care In-Network	No charge
Diagnostic Lab Work In-Network	No charge
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Inpatient Hospital Stay	$500 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Outpatient Rehabilitation/Therapy In-Network	$30 copay (ded does not apply)
Mental/Behavioral Inpatient Services In-Network	$500 copay
Mental/Behavioral Outpatient Services In- Network	$30 copay (ded does not apply)
Chiropractic Services In-Network	$55 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$250 copay
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay
Urgent care (NON-emergency room care) In-Network	$60 copay (ded does not apply)
Ambulance	0% coinsurance
Prescription Drugs	
Tier 1 Drug	$10 copay
Tier 2 Drug	$40 copay
Tier 3 Drug	$80 copay
Annual Prescription Drug Deductible Individual	$150 Deductible
Annual Prescription Drug Deductible Family	$300 Deductible

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Empire Connection Gold EPO 25/50
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$8,500
Annual Out-of-Pocket Maximum In-Network - Family	$17,000
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	No charge
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	No charge
Inpatient Hospital Stay	$500 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	No charge
Outpatient Rehabilitation/Therapy In-Network	$25 copay
Mental/Behavioral Inpatient Services In-Network	$500 copay
Mental/Behavioral Outpatient Services In- Network	$25 copay
Chiropractic Services In-Network	$50 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$500 copay
Emergency/Urgent Care	
Emergency Room In-Network	$750 copay
Urgent care (NON-emergency room care) In-Network	$50 copay
Ambulance	$750 copay
Prescription Drugs	
Tier 1 Drug	$10 copay
Tier 2 Drug	$40 copay
Tier 3 Drug	$80 copay
Annual Prescription Drug Deductible Individual	$150 Deductible
Annual Prescription Drug Deductible Family	$300 Deductible

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Empire Connection Gold EPO 30/55
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$1,000
Annual Plan Year Deductible In-Network - Family	$2,000
Annual Out-of-Pocket Maximum In-Network - Individual	$6,750
Annual Out-of-Pocket Maximum In-Network - Family	$13,500
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$30 copay (ded does not apply)
Specialist Visit In-Network	$55 copay (ded does not apply)
OB/GYN Preventive Care In-Network	No charge
Diagnostic Lab Work In-Network	No charge
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Inpatient Hospital Stay	$500 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Outpatient Rehabilitation/Therapy In-Network	$30 copay (ded does not apply)
Mental/Behavioral Inpatient Services In-Network	$500 copay
Mental/Behavioral Outpatient Services In- Network	$30 copay (ded does not apply)
Chiropractic Services In-Network	$55 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$250 copay
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay
Urgent care (NON-emergency room care) In-Network	$60 copay (ded does not apply)
Ambulance	0% coinsurance
Prescription Drugs	
Tier 1 Drug	$10 copay
Tier 2 Drug	$40 copay
Tier 3 Drug	$80 copay
Annual Prescription Drug Deductible Individual	$150 Deductible
Annual Prescription Drug Deductible Family	$300 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 Liberty Gold EPO 25/50 ZD
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$6,250
Annual Out-of-Pocket Maximum In-Network - Family	$12,500
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 copay
Specialist Visit In-Network	$50 copay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	No Charge (Designated Diagnostic Provider) $60 copay (Non-Designated Diagnostic Provider)
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$50 copay (Radiology) $150 copay (Major Diagnostic)
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	$150 copay at Physicians Office, $500 copay at Hospital
Outpatient Rehabilitation/Therapy In-Network	$50 copay
Mental/Behavioral Inpatient Services In-Network	$500 copay
Mental/Behavioral Outpatient Services In- Network	$25 copay
Chiropractic Services In-Network	$50 copay
Durable Medical Equipment	No Charge (Precertification required for items over $500)
Outpatient Surgery (Facility Fee) In-Network	$150 copay
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 (N/A Tier 1)
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Liberty Gold EPO 30/60 G
Deductible/Out-of-Pocket Max	
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	$6,650
Annual Out-of-Pocket Maximum In-Network - Family	$13,300
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$30 copay
Specialist Visit In-Network	$60 copay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	No Charge (Designated Dianostic Provider) 50% coinsurance after ded. (Non-Desginated Diagnostic Provider)
Diagnostic X-Rays In-Network	$35 copay (after ded)
Radiology/Major Diagnostic Test In-network	$35 copay after ded. (Radiology) $100 copay (Major Radiology)
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
Mental/Behavioral Inpatient Services In-Network	$500 copay/day ($2000 max) (after ded)
Mental/Behavioral Outpatient Services In- Network	$30 copay per visit; No Charge after ded. (partial hospitalization)
Chiropractic Services In-Network	$60 copay
Durable Medical Equipment	0% Coinsurance (after ded) (Precertification required for items over $500)
Outpatient Surgery (Facility Fee) In-Network	$150 copay at Physician Office(after ded), $250 copay at Hospital (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (not subject to ded)
Urgent care (NON-emergency room care) In-Network	$75 copay (not subjet to ded)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded)
Tier 2 Drug	$50 copay (after ded)
Tier 3 Drug	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Liberty Gold HSA 1500 M
Deductible/Out-of-Pocket Max	
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	$5,750
Annual Out-of-Pocket Maximum In-Network - Family	$11,500
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Liberty Gold EPO 30/60
Deductible/Out-of-Pocket Max	
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	$8,000
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	$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 (Designated Diagnostic Provider) 50% Coinsurance after ded. (Non-Designated Diagnostic Provider)
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	$30 copay (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$30 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 (N/A Tier 1)
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Metro Gold EPO 25/40
Deductible/Out-of-Pocket Max	
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	$6,250
Annual Out-of-Pocket Maximum In-Network - Family	$12,500
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 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	No Charge (Designated Diagnostic Provider) 50% Coinsurance after ded. (Non-Designated Diagnostic Provider)
Diagnostic X-Rays In-Network	$50 copay (after ded)
Radiology/Major Diagnostic Test In-network	$50 copay (after ded) - Radiology $150 copay (after ded) - Major Diagnostic
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	0 copay after ded. (Freestanding Facility)$500 copay after ded. (Hospit
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	$25 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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Metro Gold EPO 25/40 G
Deductible/Out-of-Pocket Max	
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	$6,250
Annual Out-of-Pocket Maximum In-Network - Family	$12,500
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 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	No Charge (Designated Diagnostic Provider) 50% Coinsurance after ded. (Non-Designated Diagnostic Provider)
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 (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$25 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	$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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Prime Silver Premier
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$4,800
Annual Plan Year Deductible In-Network - Family	$9,600
Annual Out-of-Pocket Maximum In-Network - Individual	$8,800
Annual Out-of-Pocket Maximum In-Network - Family	$17,600
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First visit, free. Thereafter, $35 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
Diagnostic Lab Work In-Network	$35 (PCP)/$75 (Specialist) Co-Pay (not subject to ded)
Diagnostic X-Rays In-Network	$35 (PCP)/$75 (Specialist) Co-Pay (after ded)
Radiology/Major Diagnostic Test In-network	$75 Co-Pay (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$450 Co-Pay (after ded)
Inpatient Hospital Stay	40% Coinsurance, per admission (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$450 Co-Pay (after ded)
Outpatient Rehabilitation/Therapy In-Network	$35 (PCP)/$75 (Specialist) Co-Pay (after ded)
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance, per admission (after ded)
Mental/Behavioral Outpatient Services In- Network	First visit, free. Thereafter, $35 Co-Pay (not subject to ded)
Chiropractic Services In-Network	$75 Co-Pay (not subject to ded)
Durable Medical Equipment	30% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	$450 Co-Pay (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	$1000 Co-Pay (after ded)
Urgent care (NON-emergency room care) In-Network	$100 Co-Pay (after ded)
Ambulance	$450 Co-Pay (after ded)
Prescription Drugs	
Tier 1 Drug	$0 Co-Pay
Tier 2 Drug	$40 Co-Pay
Tier 3 Drug	$80 Co-Pay
Annual Prescription Drug Deductible Individual	$0 Deductible
Annual Prescription Drug Deductible Family	$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 Prime Silver HSA
Deductible/Out-of-Pocket Max	
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	$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	$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	$450 Co-Pay (after ded)
Inpatient Hospital Stay	40% Coinsurance, per admission (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$450 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, per admission (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	$450 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	$450 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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Empire Silver EPO 40/70
Deductible/Out-of-Pocket Max	
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	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$40 copay (ded does not apply)
Specialist Visit In-Network	$70 copay (ded does not apply)
OB/GYN Preventive Care In-Network	No charge
Diagnostic Lab Work In-Network	$20 copay (ded does not apply)
Diagnostic X-Rays In-Network	$75 copay
Radiology/Major Diagnostic Test In-network	50% coinsurance
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Inpatient Hospital Stay	50% coinsurance
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance
Outpatient Rehabilitation/Therapy In-Network	$40 copay (ded does not apply)
Mental/Behavioral Inpatient Services In-Network	50% coinsurance
Mental/Behavioral Outpatient Services In- Network	$40 copay (ded does not apply)
Chiropractic Services In-Network	$70 copay (ded does not apply)
Durable Medical Equipment	50% coinsurance after deductible
Outpatient Surgery (Facility Fee) In-Network	50% coinsurance after deductible
Emergency/Urgent Care	
Emergency Room In-Network	50% coinusrance after deductible
Urgent care (NON-emergency room care) In-Network	$75 copay (ded does not apply)
Ambulance	50% coinsurance after deductible
Prescription Drugs	
Tier 1 Drug	$25 copay
Tier 2 Drug	$75 copay
Tier 3 Drug	$90 copay
Annual Prescription Drug Deductible Individual	$200 Deductible
Annual Prescription Drug Deductible Family	$400 Deductible

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Empire Silver EPO HSA 3500
Deductible/Out-of-Pocket Max	
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	$7,450
Annual Out-of-Pocket Maximum In-Network - Family	$14,900
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$20 copay
Specialist Visit In-Network	$50 copay
OB/GYN Preventive Care In-Network	No charge
Diagnostic Lab Work In-Network	$25 copay
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Inpatient Hospital Stay	$1,500 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Outpatient Rehabilitation/Therapy In-Network	$50 copay
Mental/Behavioral Inpatient Services In-Network	$1,500 copay
Mental/Behavioral Outpatient Services In- Network	$20 copay
Chiropractic Services In-Network	$50 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$500 copay
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay
Urgent care (NON-emergency room care) In-Network	$100 copay
Ambulance	$500 copay
Prescription Drugs	
Tier 1 Drug	$10 copay
Tier 2 Drug	$50 copay
Tier 3 Drug	$90 copay
Annual Prescription Drug Deductible Individual	Combined with In-Network medical deductible
Annual Prescription Drug Deductible Family	Combined with In-Network out-of-pocket limit

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Empire Blue Access Silver EPO HSA 3000
Deductible/Out-of-Pocket Max	
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	$7,450
Annual Out-of-Pocket Maximum In-Network - Family	$14,900
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$20 copay
Specialist Visit In-Network	$50 copay
OB/GYN Preventive Care In-Network	No charge
Diagnostic Lab Work In-Network	$25 copay
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Inpatient Hospital Stay	$1,500 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Outpatient Rehabilitation/Therapy In-Network	$50 copay
Mental/Behavioral Inpatient Services In-Network	$1,500 copay
Mental/Behavioral Outpatient Services In- Network	$20 copay
Chiropractic Services In-Network	$50 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$500 copay
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay
Urgent care (NON-emergency room care) In-Network	$100 copay
Ambulance	$500 copay
Prescription Drugs	
Tier 1 Drug	$10 copay
Tier 2 Drug	$50 copay
Tier 3 Drug	$90 copay
Annual Prescription Drug Deductible Individual	Combined with In-Network medical deductible
Annual Prescription Drug Deductible Family	Combined with In-Network out-of-pocket limit

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Empire Blue Access Silver EPO 25/50
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$4,550
Annual Plan Year Deductible In-Network - Family	$9,100
Annual Out-of-Pocket Maximum In-Network - Individual	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$25 copay (ded does not apply)
Specialist Visit In-Network	$50 copay (ded does not apply)
OB/GYN Preventive Care In-Network	No charge
Diagnostic Lab Work In-Network	$20 copay (ded does not apply)
Diagnostic X-Rays In-Network	$75 copay
Radiology/Major Diagnostic Test In-network	50% coinsurance
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance
Inpatient Hospital Stay	50% coinsurance
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance
Outpatient Rehabilitation/Therapy In-Network	$25 copay (ded does not apply)
Mental/Behavioral Inpatient Services In-Network	50% coinsurance
Mental/Behavioral Outpatient Services In- Network	$25 copay (ded does not apply)
Chiropractic Services In-Network	$50 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	50% coinsurance
Emergency/Urgent Care	
Emergency Room In-Network	50% coinsurance
Urgent care (NON-emergency room care) In-Network	$50 copay (ded does not apply)
Ambulance	50% coinsurance
Prescription Drugs	
Tier 1 Drug	$25 copay
Tier 2 Drug	$75 copay
Tier 3 Drug	$90 copay
Annual Prescription Drug Deductible Individual	$200 does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$400 does not apply to Tier 1 drugs

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

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Empire Connection Silver EPO 40/70
Deductible/Out-of-Pocket Max	
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	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$40 copay (ded does not apply)
Specialist Visit In-Network	$70 copay (ded does not apply)
OB/GYN Preventive Care In-Network	No charge
Diagnostic Lab Work In-Network	$20 copay (ded does not apply)
Diagnostic X-Rays In-Network	$75 copay
Radiology/Major Diagnostic Test In-network	50% coinsurance
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance
Inpatient Hospital Stay	50% coinsurance
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance
Outpatient Rehabilitation/Therapy In-Network	$40 copay (ded does not apply)
Mental/Behavioral Inpatient Services In-Network	50% coinsurance
Mental/Behavioral Outpatient Services In- Network	$40 copay (ded does not apply)
Chiropractic Services In-Network	$70 copay (ded does not apply)
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	50% coinsurance
Emergency/Urgent Care	
Emergency Room In-Network	50% coinsurance
Urgent care (NON-emergency room care) In-Network	$75 copay (ded does not apply)
Ambulance	50% coinsurance
Prescription Drugs	
Tier 1 Drug	$25 copay
Tier 2 Drug	$75 copay
Tier 3 Drug	$90 copay
Annual Prescription Drug Deductible Individual	$200 does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$400 does not apply to Tier 1 drugs

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
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$50 copay
Specialist Visit In-Network	$100 copay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$60 copay
Diagnostic X-Rays In-Network	$150 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$1400 copay
Inpatient Hospital Stay	$2800 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	$2800 copay
Mental/Behavioral Outpatient Services In- Network	$50 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
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	$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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Liberty Silver EPO 40/80
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$3,250
Annual Plan Year Deductible In-Network - Family	$6,500
Annual Out-of-Pocket Maximum In-Network - Individual	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$40 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	50% Coinsurance (after ded)
Diagnostic X-Rays In-Network	40% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	40% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	40% Coinsurance (after ded)
Inpatient Hospital Stay	40% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	40% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$80 copay (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$40 copay (not subject to ded)
Chiropractic Services In-Network	$80 copay (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	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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Liberty Silver EPO 30/60 G
Deductible/Out-of-Pocket Max	
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	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$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	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	$60 copay (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$30 copay (not subject to ded)
Chiropractic Services In-Network	$60 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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Liberty Silver HSA 4000 M
Deductible/Out-of-Pocket Max	
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	$7,350
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	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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Metro Silver EPO 50/100 ZD
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$50 copay
Specialist Visit In-Network	$100 copay
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$60 copay
Diagnostic X-Rays In-Network	$150 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$1400 copay
Inpatient Hospital Stay	$2800 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	$2800 copay
Mental/Behavioral Outpatient Services In- Network	$50 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	$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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Metro Silver EPO 30/80 G
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$3,750
Annual Plan Year Deductible In-Network - Family	$7,500
Annual Out-of-Pocket Maximum In-Network - Individual	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	$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	50% Coinsurance (after ded)
Diagnostic X-Rays In-Network	40% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	40% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	40% Coinsurance (after ded)
Inpatient Hospital Stay	40% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	40% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$80 copay (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$30 copay (not subject to ded)
Chiropractic Services In-Network	$80 copay (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	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	$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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Prime Bronze HSA
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$6,750
Annual Plan Year Deductible In-Network - Family	$13,500
Annual Out-of-Pocket Maximum In-Network - Individual	$7,500
Annual Out-of-Pocket Maximum In-Network - Family	$15,000
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	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, per admission (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, per admission (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 copay (after ded)
Ambulance	50% Coinsurance (after ded)
Prescription Drugs	
Tier 1 Drug	$15 copay (after ded)
Tier 2 Drug	$65 copay (after ded)
Tier 3 Drug	$100 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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Prime Bronze Premier
Deductible/Out-of-Pocket Max	
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	$9,100
Annual Out-of-Pocket Maximum In-Network - Family	$18,200
Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Plan Year Deductible Out-of-Network - Family	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Cost Sharing	
Primary Care Visit In-Network	First visit, free. 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, per admission (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, per admission (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 copay (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.

HealthPass BENEFITS EXCHANGE

2023 Summary of Benefits

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

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

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.