

	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



	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



	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



	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)



	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.	→



	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.	



	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
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	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



	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.	



	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	yeso copay at nospital (arter aca)
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)



Deductible/Out-of-Pocket Max Annual Plan Year Deductible In-Network - Individual Annual Plan Year Deductible In-Network - Family Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Family Annual Out-of-Pocket Maximum Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family Cost Sharing	\$1,500 \$3,000 \$5,750 \$11,500 N/A N/A N/A N/A 10% Coinsurance (after ded) 10% Coinsurance (after ded)
Annual Plan Year Deductible In-Network - Family Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Family Annual Out-of-Pocket Maximum Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family	\$3,000 \$5,750 \$11,500 N/A N/A N/A N/A 10% Coinsurance (after ded)
Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Family Annual Out-of-Pocket Maximum Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family	\$5,750 \$11,500 N/A N/A N/A N/A 10% Coinsurance (after ded)
Annual Out-of-Pocket Maximum In-Network - Family Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Family Annual Out-of-Pocket Maximum Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family	\$11,500 N/A N/A N/A N/A 10% Coinsurance (after ded)
Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Family Annual Out-of-Pocket Maximum Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A N/A N/A N/A N/A 10% Coinsurance (after ded)
Annual Plan Year Deductible Out-of-Network - Family Annual Out-of-Pocket Maximum Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A N/A N/A 10% Coinsurance (after ded)
Annual Out-of-Pocket Maximum Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A N/A 10% Coinsurance (after ded)
Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A 10% Coinsurance (after ded)
·	10% Coinsurance (after ded)
Cost Sharing	
Primary Care Visit In-Network	10% Coinsurance (after ded)
Specialist Visit In-Network	2070 Combarance (arter dea)
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



	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)



	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	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	3300 Copay at Hospital (after ded)
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
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	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	3300 Copay at Hospital (after ded)
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
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	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.	-



	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.	



	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



	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
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Empire Blue Access Silver EPO HSA 3000
\$3,000
\$6,000
\$7,450
\$14,900
N/A
N/A
N/A
N/A
\$20 copay
\$50 copay
No charge
\$25 copay
\$50 copay
\$250 copay
0% coinsurance
\$1,500 copay
0% coinsurance
\$50 copay
\$1,500 copay
\$20 copay
\$50 copay
50% coinsurance
\$500 copay
\$500 copay
\$100 copay
\$500 copay
\$10 copay
\$50 copay
\$90 copay
Combined with In-Network medical deductible



	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.	



	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.	



	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
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	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



	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.	



	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



	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.	+



Deductible/Out-of-Pocket Max Annual Plan Year Deductible In-Network - Individual Annual Plan Year Deductible In-Network - Individual S3,750 Annual Plan Year Deductible In-Network - Family S18,200 Annual Out-of-Pocket Maximum In-Network - Family S18,200 Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Individual Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family N/A Cost Sharing Primary Care Visit In-Network S80 copay (not subject to ded) Specialist Visit In-Network S80 copay (not subject to ded) OB/GYN Preventive Care In-Network No Charge Diagnostic Lab Work In-Network Diagnostic X-Rays In-Network A0% Coinsurance (after ded) Diagnostic X-Rays In-Network A0% Coinsurance (after ded) Inpatient Surgery (Physician/Surgeon Fee) In-Network A0% Coinsurance (after ded) Outpatient Surgery (Physician/Surgeon Fee) In-Network A0% Coinsurance (after ded) Outpatient Rehabilitation/Therapy In-Network S80 copay (not subject to ded) Mental/Behavioral Inpatient Services In-Network S80 copay (not subject to ded) Mental/Behavioral Outpatient Services In-Network S80 copay (not subject to ded) Durable Medical Equipment A0% Coinsurance (after ded) Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Durable Medical Equipment A0% Coinsurance (after ded) Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Ambulance Terregency Virgent Care Emergency Room In-Network No Charge Terregency Room In-Network S80 copay (not subject to ded) Terred Drugs S50 copay (not subject to ded)		Oxford Metro Silver EPO 30/80 G
Annual Plan Year Deductible In-Network - Family Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family Annual Plan Year Deductible Out-of-Network - Family Annual Plan Year Deductible Out-of-Network - Family Annual Plan Year Deductible Out-of-Network - Family Annual Out-of-Pocket Maximum Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family N/A Annual Out-of-Pocket Maximum	Deductible/Out-of-Pocket Max	
Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Family N/A Annual Plan Year Deductible Out-of-Network - Family N/A Annual Out-of-Pocket Maximum Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family N/A Cost Sharring Primary Care Visit In-Network Specialist Lab Work In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Lab Work In-Network Specialist Visit In-Network Specialist Alphanology (Interpretation of Special Specia	Annual Plan Year Deductible In-Network - Individual	\$3,750
Annual Out-of-Pocket Maximum In-Network - Family Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Family Annual Plan Year Deductible Out-of-Network - Family Annual Out-of-Pocket Maximum Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family N/A Cost Sharing Primary Care Visit In-Network Specialist Visit In-Network Anoual Out-of-Pocket Maximum Out-of-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Anoual Out-of-Pocket Maximum Out-of-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network No Charge Diagnostic Lab Work In-Network Specialist Visit In-Network Adv Coinsurance (after ded) Diagnostic X-Rays In-Network Adv Coinsurance (after ded) Inpatient Surgery (Physician/Surgeon Fee) In-Network Adv Coinsurance (after ded) Untpatient Surgery (Physician/Surgeon Fee) In-Network Adv Coinsurance (after ded) Untpatient Surgery (Physician/Surgeon Fee) In-Network Specialist Visit In-Network Specialist Visit In-Network Adv Coinsurance (after ded) Mental/Behavioral Inpatient Services In-Network Specialist Visit In-Netw	Annual Plan Year Deductible In-Network - Family	\$7,500
Annual Plan Year Deductible Out-of-Network - Individual Annual Plan Year Deductible Out-of-Network - Family 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 Annual Out-of-Pocket Maximum Out-of-Network - Family N/A Annual Out-of-Pocket Maximum Out-of-Network - Family N/A Annual Out-of-Pocket Maximum Out-of-Network - Family N/A Annual Out-of-Pocket Maximum Out-of-Network - Family N/A Annual Out-of-Pocket Maximum Out-of-Network - Family N/A S30 copay (not subject to ded) Specialist Visit In-Network S30 copay (not subject to ded) No Charge Diagnostic Lab Work In-Network No Charge Diagnostic X-Rays In-Network Ad% Coinsurance (after ded) Diagnostic X-Rays In-Network Ad% Coinsurance (after ded) Inpatient Surgery (Physician/Surgeon Fee) In-Network Ad% Coinsurance (after ded) Unpatient Surgery (Physician/Surgeon Fee) In-Network Ad% Coinsurance (after ded) Outpatient Surgery (Physician/Surgeon Fee) In-Network S80 copay (not subject to ded) Mental/Behavioral Inpatient Services In-Network S80 copay (not subject to ded) Mental/Behavioral Outpatient Services In-Network S80 copay (not subject to ded) Chiropractic Services In-Network S80 copay (not subject to ded) Durable Medical Equipment Ad% Coinsurance (after ded) Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Emergency/Urgent Care Emergency/Orgent Care	Annual Out-of-Pocket Maximum In-Network - Individual	\$9,100
Annual Plan Year Deductible Out-of-Network - Family Annual Out-of-Pocket Maximum Out-of-Network - Individual N/A Annual Out-of-Pocket Maximum Out-of-Network - Individual N/A Annual Out-of-Pocket Maximum Out-of-Network - Family N/A Socts Sharing Primary Care Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network No Charge Diagnostic Lab Work In-Network No Charge Diagnostic Lab Work In-Network No Coinsurance (after ded) Diagnostic X-Rays In-Network Ad% Coinsurance (after ded) Inpatient Surgery (Physician/Surgeon Fee) In-Network Ad% Coinsurance (after ded) Inpatient Hospital Stay Outpatient Surgery (Physician/Surgeon Fee) In-Network Ad% Coinsurance (after ded) Outpatient Rehabilitation/Therapy In-Network Specialist Visit In-Network Ad% Coinsurance (after ded) Mental/Behavioral Inpatient Services In-Network Ad% Coinsurance (after ded) Mental/Behavioral Outpatient Services In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Ad% Coinsurance (after ded) Mental/Behavioral Outpatient Services In-Network Specialist Visit In-Network Adv Coinsurance (after ded) No Charge No Coinsurance (after ded) No Charge No Coinsurance (after ded) N	Annual Out-of-Pocket Maximum In-Network - Family	\$18,200
Annual Out-of-Pocket Maximum Out-of-Network - Individual Annual Out-of-Pocket Maximum Out-of-Network - Family N/A Annual Out-of-Pocket Maximum Out-of-Network - Family N/A Annual Out-of-Pocket Maximum Out-of-Network - Family Primary Care Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network No Charge Diagnostic Lab Work In-Network No Charge Diagnostic X-Rays In-Network Diagnostic X-Rays In-Network Ad% Coinsurance (after ded) Inpatient Surgery (Physician/Surgeon Fee) In-Network Inpatient Surgery (Physician/Surgeon Fee) In-Network Ad% Coinsurance (after ded) Outpatient Surgery (Physician/Surgeon Fee) In-Network Ad% Coinsurance (after ded) Outpatient Rehabilitation/Therapy In-Network Specialist Visit In-Network Ad% Coinsurance (after ded) Mental/Behavioral Inpatient Services In-Network Ad% Coinsurance (after ded) Mental/Behavioral Outpatient Services In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Ad% Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Ad% Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Adw Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Specialist Visit In-Network Adw Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Adw Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Adw Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Adw Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Specialist Visit In-Network Adw Coinsurance (after	Annual Plan Year Deductible Out-of-Network - Individual	N/A
Annual Out-of-Pocket Maximum Out-of-Network - Family Cost Sharing Primary Care Visit In-Network Specialist Visit In-Network No Charge Diagnostic Lab Work In-Network Diagnostic Lab Work In-Network Radiology/Major Diagnostic Test In-network Au% Coinsurance (after ded) Inpatient Surgery (Physician/Surgeon Fee) In-Network Au% Coinsurance (after ded) Outpatient Surgery (Physician/Surgeon Fee) In-Network Rental/Behavioral Inpatient Services In-Network Rental/Behavioral Outpatient Services In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Rental/Behavioral Outpatient Services In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Au% Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Au% Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Au% Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Au% Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Au% Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Au% Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Au% Coinsurance (after ded) Chiropractic Services In-Net	Annual Plan Year Deductible Out-of-Network - Family	N/A
Cost Sharing Primary Care Visit In-Network Specialist Visit In-Network No Charge Diagnostic Lab Work In-Network Diagnostic X-Rays In-Network Radiology/Major Diagnostic Test In-network Adw. Coinsurance (after ded) Inpatient Surgery (Physician/Surgeon Fee) In-Network Inpatient Surgery (Physician/Surgeon Fee) In-Network Adw. Coinsurance (after ded) Outpatient Surgery (Physician/Surgeon Fee) In-Network Adw. Coinsurance (after ded) Outpatient Rehabilitation/Therapy In-Network Specialist Visit In-Network Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Specialist Visit In-Network Specialist Visit In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Specialist Visit In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Specialist Visit In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Adw. Coinsurance (after ded) Chiropractic Services In-Network Adw. Coinsurance (afte	Annual Out-of-Pocket Maximum Out-of-Network - Individual	N/A
Primary Care Visit In-Network Specialist Visit In-Network No Charge Diagnostic Lab Work In-Network Diagnostic Lab Work In-Network Diagnostic X-Rays In-Network Ad% Coinsurance (after ded) Radiology/Major Diagnostic Test In-network Ad% Coinsurance (after ded) Inpatient Surgery (Physician/Surgeon Fee) In-Network Ad% Coinsurance (after ded) Inpatient Hospital Stay Ad% Coinsurance (after ded) Outpatient Surgery (Physician/Surgeon Fee) In-Network Ad% Coinsurance (after ded) Outpatient Rehabilitation/Therapy In-Network Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network S80 copay (not subject to ded) Mental/Behavioral Outpatient Services In-Network S80 copay (not subject to ded) Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Outpatient Care (NON-emergency room care) In-Network S80 copay (not subject to ded) No Charge Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Annual Out-of-Pocket Maximum Out-of-Network - Family	N/A
Specialist Visit In-Network OB/GYN Preventive Care In-Network Diagnostic Lab Work In-Network Diagnostic X-Rays In-Network Diagnostic X-Rays In-Network Radiology/Major Diagnostic Test In-network A0% Coinsurance (after ded) Inpatient Hospital Stay A0% Coinsurance (after ded) Outpatient Surgery (Physician/Surgeon Fee) In-Network A0% Coinsurance (after ded) Mental/Behavioral Inpatient Services In-Network S80 copay (not subject to ded) Mental/Behavioral Outpatient Services In-Network S80 copay (not subject to ded) Durable Medical Equipment A0% Coinsurance (after ded) Outpatient Surgery (Facility Fee) In-Network A0% Coinsurance (after ded) Emergency/Urgent Care Emergency Room In-Network S80 copay (not subject to ded) Temporatic Services In-Network S80 copay (not subject to ded) Remergency/Urgent Care Emergency Room In-Network S80 copay (not subject to ded) No Charge Prescription Drugs Tier 1 Drug S10 copay (not subject to ded)	Cost Sharing	
Diagnostic Lab Work In-Network Diagnostic Lab Work In-Network Diagnostic X-Rays In-Network A0% Coinsurance (after ded) Radiology/Major Diagnostic Test In-network A0% Coinsurance (after ded) Inpatient Surgery (Physician/Surgeon Fee) In-Network A0% Coinsurance (after ded) Inpatient Hospital Stay A0% Coinsurance (after ded) Outpatient Surgery (Physician/Surgeon Fee) In-Network A0% Coinsurance (after ded) Outpatient Surgery (Physician/Surgeon Fee) In-Network A0% Coinsurance (after ded) Outpatient Rehabilitation/Therapy In-Network A0% Coinsurance (after ded) Mental/Behavioral Inpatient Services In-Network A0% Coinsurance (after ded) Mental/Behavioral Outpatient Services In-Network A0% Coinsurance (after ded) Chiropractic Services In-Network A0% Coinsurance (after ded) Outpatient Surgery (Facility Fee) In-Network A0% Coinsurance (after ded) Outpatient Surgery (Facility Fee) In-Network A0% Coinsurance (after ded) Emergency/Urgent Care Emergency Room In-Network A0% Coinsurance (after ded) Urgent care (NON-emergency room care) In-Network Anbulance Prescription Drugs Tier 1 Drug S10 copay (not subject to ded)	Primary Care Visit In-Network	\$30 copay (not subject to ded)
Diagnostic Lab Work In-Network Diagnostic X-Rays In-Network Radiology/Major Diagnostic Test In-network A0% Coinsurance (after ded) Inpatient Surgery (Physician/Surgeon Fee) In-Network Inpatient Hospital Stay Outpatient Surgery (Physician/Surgeon Fee) In-Network Outpatient Rehabilitation/Therapy In-Network Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Chiropractic Services In-Network Durable Medical Equipment Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Durable Medical Equipment Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Durable Medical Equipment Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Durable Medical Equipment Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) Durable Medical Equipment S80 copay (not subject to ded) Outpatient Surgery (Facility Fee) In-Network S80 copay (not subject to ded) S80 copay (not subject to ded) T80 copay (not subject to ded) No Charge Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Specialist Visit In-Network	\$80 copay (not subject to ded)
Diagnostic X-Rays In-Network Radiology/Major Diagnostic Test In-network A0% Coinsurance (after ded) Inpatient Surgery (Physician/Surgeon Fee) In-Network A0% Coinsurance (after ded) Inpatient Hospital Stay A0% Coinsurance (after ded) Outpatient Surgery (Physician/Surgeon Fee) In-Network A0% Coinsurance (after ded) Outpatient Surgery (Physician/Surgeon Fee) In-Network A0% Coinsurance (after ded) Outpatient Rehabilitation/Therapy In-Network \$80 copay (not subject to ded) Mental/Behavioral Inpatient Services In-Network A0% Coinsurance (after ded) Chiropractic Services In-Network \$80 copay (not subject to ded) Durable Medical Equipment A0% Coinsurance (after ded) Outpatient Surgery (Facility Fee) In-Network A0% Coinsurance (after ded) Emergency/Urgent Care Emergency Room In-Network \$80 copay (not subject to ded) Urgent care (NON-emergency room care) In-Network \$80 copay (not subject to ded) Tier 1 Drug \$10 copay (not subject to ded)	OB/GYN Preventive Care In-Network	No Charge
Radiology/Major Diagnostic Test In-network Inpatient Surgery (Physician/Surgeon Fee) In-Network Inpatient Hospital Stay Outpatient Surgery (Physician/Surgeon Fee) In-Network Outpatient Surgery (Physician/Surgeon Fee) In-Network Outpatient Rehabilitation/Therapy In-Network Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Chiropractic Services In-Network S80 copay (not subject to ded) Chiropractic Services In-Network S80 copay (not subject to ded) Outpatient Surgery (Facility Fee) In-Network Emergency/Urgent Care Emergency Room In-Network S80 copay (not subject to ded) Urgent care (NON-emergency room care) In-Network S80 copay (not subject to ded) Tier 1 Drug \$10 copay (not subject to ded)	Diagnostic Lab Work In-Network	50% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network Inpatient Hospital Stay Outpatient Surgery (Physician/Surgeon Fee) In-Network Outpatient Surgery (Physician/Surgeon Fee) In-Network Outpatient Rehabilitation/Therapy In-Network Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Sa0 copay (not subject to ded) Chiropractic Services In-Network Sa0 copay (not subject to ded) Durable Medical Equipment 40% Coinsurance (after ded) Outpatient Surgery (Facility Fee) In-Network 40% Coinsurance (after ded) Urgent Care Emergency Room In-Network 50% Coinsurance (after ded) Urgent care (NON-emergency room care) In-Network Ambulance Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Diagnostic X-Rays 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 Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Radiology/Major Diagnostic Test In-network	40% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network Outpatient Rehabilitation/Therapy In-Network Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Sao copay (not subject to ded) Chiropractic Services In-Network Sao copay (not subject to ded) Durable Medical Equipment 40% Coinsurance (after ded) Outpatient Surgery (Facility Fee) In-Network Emergency/Urgent Care Emergency Room In-Network Sao copay (not subject to ded) Urgent care (NON-emergency room care) In-Network Sao copay (not subject to ded) No Charge Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Inpatient Surgery (Physician/Surgeon Fee) In-Network	40% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Sa0 copay (not subject to ded) Chiropractic Services In-Network Sa0 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) No Charge Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Inpatient Hospital Stay	40% Coinsurance (after ded)
Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network S30 copay (not subject to ded) Chiropractic Services In-Network S80 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)	Outpatient Surgery (Physician/Surgeon Fee) 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) Cutpatient 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)	Outpatient Rehabilitation/Therapy In-Network	\$80 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)	Mental/Behavioral Inpatient Services In-Network	40% Coinsurance (after 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 Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Mental/Behavioral Outpatient Services In- Network	\$30 copay (not subject to ded)
Outpatient Surgery (Facility Fee) In-Network Emergency/Urgent Care Emergency Room In-Network Urgent care (NON-emergency room care) In-Network Ambulance Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Chiropractic Services In-Network	\$80 copay (not subject to ded)
Emergency/Urgent Care Emergency Room In-Network Urgent care (NON-emergency room care) In-Network Ambulance Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Durable Medical Equipment	40% Coinsurance (after ded)
Emergency Room In-Network Urgent care (NON-emergency room care) In-Network \$80 copay (not subject to ded) No Charge Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Outpatient Surgery (Facility Fee) In-Network	40% 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)	Emergency/Urgent Care	
Ambulance No Charge Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Emergency Room In-Network	50% Coinsurance (after ded)
Prescription Drugs Tier 1 Drug \$10 copay (not subject to ded)	Urgent care (NON-emergency room care) In-Network	\$80 copay (not subject to ded)
Tier 1 Drug \$10 copay (not subject to ded)	Ambulance	No Charge
	Prescription Drugs	
Tier 2 Drug	Tier 1 Drug	\$10 copay (not subject to ded)
nei 2 Diug 303 copay (atter deu)	Tier 2 Drug	\$65 copay (after ded)
Tier 3 Drug \$95 copay (after ded)	Tier 3 Drug	\$95 copay (after ded)
Annual Prescription Drug Deductible Individual \$200 Deductible/member	Annual Prescription Drug Deductible Individual	\$200 Deductible/member
Annual Prescription Drug Deductible Family \$200 Deductible/member		\$200 Deductible/member



	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)
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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



	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 Surgery (Frysician) Surgeon Fee) In-Network 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	E00/ Coincurance (after ded)
Emergency Room In-Network	50% Coinsurance (after ded) 50% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	, ,
Ambulance	50% Coinsurance (after ded)
Prescription Drugs	CFO commission to the CFO
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



	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
Place refer to the official Summary of Panelite and Courses (SSC) for complete summary of courses	



	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.	+