



## 2023 Summary of Benefits

	EmblemHealth Prime Platinum Premier
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	\$400 copay
Urgent care (NON-emergency room care) In-Network	\$100 copay
Ambulance	\$250 copay
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Empire Platinum EPO 5/25
<b>Deductible/Out-of-Pocket Max</b>	<b>In-Network</b>
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	\$300 copay
Urgent care (NON-emergency room care) In-Network	\$75 copay
Ambulance	\$300 copay
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Empire Connection Platinum EPO 20/40
<b>Deductible/Out-of-Pocket Max</b>	<b>In-Network</b>
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	\$300 copay
Urgent care (NON-emergency room care) In-Network	\$50 copay
Ambulance	\$300 copay
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Liberty Platinum EPO
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	EmblemHealth Prime Gold Premier
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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)
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Empire Blue Access Gold EPO 30/55
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	\$500 copay
Urgent care (NON-emergency room care) In-Network	\$60 copay (ded does not apply)
Ambulance	0% coinsurance
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Empire Connection Gold EPO 25/50
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	\$750 copay
Urgent care (NON-emergency room care) In-Network	\$50 copay
Ambulance	\$750 copay
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Empire Connection Gold EPO 30/55
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	\$500 copay
Urgent care (NON-emergency room care) In-Network	\$60 copay (ded does not apply)
Ambulance	0% coinsurance
<b>Prescription Drugs</b>	
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.





## 2023 Summary of Benefits

	Oxford Liberty Gold EPO 25/50 ZD
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	\$750 copay
Urgent care (NON-emergency room care) In-Network	\$50 copay
Ambulance	No Charge
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Liberty Gold EPO 30/60 G
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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 Diagnostic Provider) 50% coinsurance after ded. (Non-Designated 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)
<b>Emergency/Urgent Care</b>	
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
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Liberty Gold HSA 1500 M
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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)
<b>Prescription Drugs</b>	
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

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## 2023 Summary of Benefits

	Oxford Liberty Gold EPO 30/60
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Metro Gold EPO 25/40
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Metro Gold EPO 25/40 G
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	EmblemHealth Prime Silver Premier
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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)
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	EmblemHealth Prime Silver HSA
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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)
<b>Prescription Drugs</b>	
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.





## 2023 Summary of Benefits

	Empire Silver EPO 40/70
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	50% coinsurance after deductible
Urgent care (NON-emergency room care) In-Network	\$75 copay (ded does not apply)
Ambulance	50% coinsurance after deductible
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Empire Silver EPO HSA 3500
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	\$500 copay
Urgent care (NON-emergency room care) In-Network	\$100 copay
Ambulance	\$500 copay
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Empire Blue Access Silver EPO HSA 3000
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	\$500 copay
Urgent care (NON-emergency room care) In-Network	\$100 copay
Ambulance	\$500 copay
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Empire Blue Access Silver EPO 25/50
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	50% coinsurance
Urgent care (NON-emergency room care) In-Network	\$50 copay (ded does not apply)
Ambulance	50% coinsurance
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Empire Connection Silver EPO 40/70
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	50% coinsurance
Urgent care (NON-emergency room care) In-Network	\$75 copay (ded does not apply)
Ambulance	50% coinsurance
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Liberty Silver EPO 50/100 ZD
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	\$1400 copay
Urgent care (NON-emergency room care) In-Network	\$100 copay
Ambulance	No Charge
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Liberty Silver EPO 40/80
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Liberty Silver EPO 30/60 G
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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
<b>Prescription Drugs</b>	
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.





## 2023 Summary of Benefits

	Oxford Liberty Silver HSA 4000 M
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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)
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Metro Silver EPO 50/100 ZD
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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
<b>Emergency/Urgent Care</b>	
Emergency Room In-Network	\$1400 copay
Urgent care (NON-emergency room care) In-Network	\$100 copay
Ambulance	No Charge
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Metro Silver EPO 30/80 G
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	EmblemHealth Prime Bronze HSA
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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)
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	EmblemHealth Prime Bronze Premier
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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)
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Metro Bronze HSA 7000 G
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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)
<b>Prescription Drugs</b>	
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.



## 2023 Summary of Benefits

	Oxford Liberty Bronze HSA 5750
<b>Deductible/Out-of-Pocket Max</b>	
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
<b>Cost Sharing</b>	
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)
<b>Emergency/Urgent Care</b>	
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)
<b>Prescription Drugs</b>	
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.