Health Pass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Anthem 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	$3,700
Annual Out-of-Pocket Maximum In-Network - Family	$7,400
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	$5 copay
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	$88 Deductible does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$175 Deductible does not apply to Tier 1 drugs

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

Health Pass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Anthem 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	$3,000
Annual Out-of-Pocket Maximum In-Network - Family	$6,000
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	$20 copay
Inpatient Hospital Stay	$500 copay/admission
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$20 copay
Outpatient Rehabilitation/Therapy In-Network	$20 copay
Mental/Behavioral Inpatient Services In-Network	$500 copay/admission
Mental/Behavioral Outpatient Services In- Network	$20 copay per visit
Chiropractic Services In-Network	$40 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$500 copay
Emergency/Urgent Care	
Emergency Room In-Network	$300 copay
Urgent care (NON-emergency room care) In-Network	$50 copay
Ambulance	$300 copay
Prescription Drugs	
Tier 1 Drug	$10 copay
Tier 2 Drug	$35 copay
Tier 3 Drug	$70 copay
Annual Prescription Drug Deductible Individual	$100 Deductible does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$200 Deductible does not apply to Tier 1 drugs

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

2024 Summary of Benefits

	EmblemHealth Select Care Platinum Premier	
Deductible/Out-of-Pocket Max	**In-Network**	**Out-of-Network**
Annual Plan Year Deductible In-Network - Individual	$100	$4,000
Annual Plan Year Deductible In-Network - Family	$200	$8,000
Annual Out-of-Pocket Maximum In-Network - Individual	$2,300	$10,000
Annual Out-of-Pocket Maximum In-Network - Family	$4,600	$20,000
Cost Sharing		
Primary Care Visit In-Network	First 3 visits, No Charge. Thereafter, $10 copay (not subject to ded)	50% coinsurance (after ded)
Specialist Visit In-Network	$35 copay (not subject to ded)	50% coinsurance (after ded)
OB/GYN Preventive Care In-Network	No Charge	50% coinsurance (after ded)
Diagnostic Lab Work In-Network	$10 (PCP)/$35 (Specialist) copay	50% coinsurance (after ded)
Diagnostic X-Rays In-Network	$10 (PCP)/$35 (Specialist) copay	50% coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	$35 (PCP)/$75 (Specialist) copay	50% coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay (after ded)	50% coinsurance (after ded)
Inpatient Hospital Stay	20% Coinsurance, per admission	50% coinsurance (after ded) (Hospice and Skilled Nursing not covered)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay (after ded)	50% coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$10 (PCP)/$35 (Specialist) copay (after ded)	Not Covered
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance (after ded), per admission	50% coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	First 3 visits, No Charge. Thereafter, $10 copay (not subject to ded)	50% coinsurance (after ded)
Chiropractic Services In-Network	$35 copay (not subject to ded)	50% coinsurance (after ded)
Durable Medical Equipment	10% Coinsurance (after ded)	Not Covered
Outpatient Surgery (Facility Fee) In-Network	$250 copay (after ded)	50% coinsurance (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	20% coinsurance (after ded)	20% coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded)	50% coinsurance (after ded)
Ambulance	$250 copay (after ded)	$250 copay (after ded)
Prescription Drugs		
Tier 1 Drug	$5 copay	Not Covered
Tier 2 Drug	$30 copay	Not Covered
Tier 3 Drug	$65 copay	Not Covered
Annual Prescription Drug Deductible Individual	$100	N/A
Annual Prescription Drug Deductible Family	$200	N/A

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

Health Pass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Liberty Platinum EPO
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$500
Annual Plan Year Deductible In-Network - Family	$1,000
Annual Out-of-Pocket Maximum In-Network - Individual	$2,450
Annual Out-of-Pocket Maximum In-Network - Family	$4,900
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	$5 copay (not subject to ded)
Chiropractic Services In-Network	$35 copay (not subject to ded)
Durable Medical Equipment	0% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	0% Coinsurance (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	$250 copay (not subject to ded)
Urgent care (NON-emergency room care) In-Network	$75 copay (not subject to ded)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded)
Tier 2 Drug	$50 copay (after ded)
Tier 3 Drug	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)

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

2024 Summary of Benefits

	Anthem Blue Access Gold EPO 50/55
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	$7,000
Annual Out-of-Pocket Maximum In-Network - Family	$14,000
Cost Sharing	
Primary Care Visit In-Network	$50 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	$50 copay (ded does not apply)
Mental/Behavioral Inpatient Services In-Network	$500 copay
Mental/Behavioral Outpatient Services In- Network	$50 copay (ded does not apply)
Chiropractic Services In-Network	$55 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$300 copay
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay
Urgent care (NON-emergency room care) In-Network	$60 copay (ded does not apply)
Ambulance	0% coinsurance
Prescription Drugs	
Tier 1 Drug	$10 copay
Tier 2 Drug	$40 copay
Tier 3 Drug	$80 copay
Annual Prescription Drug Deductible Individual	$150 Deductible
Annual Prescription Drug Deductible Family	$300 Deductible

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Anthem Connection Gold EPO 25/55
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
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	$25 copay
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	$65 copay
Tier 3 Drug	$90 copay
Annual Prescription Drug Deductible Individual	$150 Deductible
Annual Prescription Drug Deductible Family	$300 Deductible

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Anthem Connection Gold EPO 50/55
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	$7,000
Annual Out-of-Pocket Maximum In-Network - Family	$14,000
Cost Sharing	
Primary Care Visit In-Network	$50 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	$50 copay (ded does not apply)
Mental/Behavioral Inpatient Services In-Network	$500 copay
Mental/Behavioral Outpatient Services In- Network	$50 copay (ded does not apply)
Chiropractic Services In-Network	$55 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$300 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.

2024 Summary of Benefits

	EmblemHealth Select Care Gold Premier	
Deductible/Out-of-Pocket Max	**In-Network**	**Out-of-Network**
Annual Plan Year Deductible - Individual	$500	$6,000
Annual Plan Year Deductible - Family	$1,000	$12,000
Annual Out-of-Pocket Maximum - Individual	$7,800	$12,000
Annual Out-of-Pocket Maximum - Family	$15,600	$24,000
Cost Sharing		
Primary Care Visit	First 3 visits, free. Thereafter, $25 copay (not subject to ded)	50% coinsurance (after ded)
Specialist Visit	$50 copay (not subject to ded)	50% coinsurance (after ded)
OB/GYN Preventive Care	No Charge	50% coinsurance (after ded)
Diagnostic Lab Work	$25 (PCP)/$50 (Specialist) copay (not subject to ded)	50% coinsurance (after ded)
Diagnostic X-Rays	$25 (PCP)/$50 (Specialist) copay (after ded)	50% coinsurance (after ded)
Radiology/Major Diagnostic Test	$50 copay (after ded)	50% coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee)	$350 copay (after ded)	50% coinsurance (after ded)
Inpatient Hospital Stay	30% Coinsurance, per admission (after ded)	50% coinsurance (after ded) (Hospice and Skilled Nursing not covered)
Outpatient Surgery (Physician/Surgeon Fee)	$350 copay (after ded)	50% coinsurance (after ded)
Outpatient Rehabilitation/Therapy	$25 (PCP)/$50 (Specialist) copay (after ded)	Not Covered
Mental/Behavioral Inpatient Services	30% Coinsurance, per admission (after ded)	50% coinsurance per admission (after ded)
Mental/Behavioral Outpatient Services	First 3 visits, free. Thereafter, $25 copay not subject to ded	50% coinsurance (after ded)
Chiropractic Services In-Network	$50 copay not subject to ded	50% coinsurance (after ded)
Durable Medical Equipment	20% Coinsurance (after ded)	Not Covered
Outpatient Surgery (Facility Fee)	$350 copay (after ded)	50% coinsurance (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	30% coinsurance (after ded)	30% coinsurance (after ded)
Urgent care (NON-emergency room care)	$100 copay (after ded)	50% coinsurance (after ded)
Ambulance	$350 copay (after ded)	$350 copayment (after ded)
Prescription Drugs		
Tier 1 Drug	$7 copay not subject to ded	Not Covered
Tier 2 Drug	$40 copay (after ded)	Not Covered
Tier 3 Drug	$80 copay	Not Covered
Annual Prescription Drug Deductible Individual	$150 ded	N/A
Annual Prescription Drug Dedctible Family	$300 ded	N/A

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

HealthPass℠ / BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Liberty Gold EPO 25/50 ZD
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$7,000
Annual Out-of-Pocket Maximum In-Network - Family	$14,000
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	$60 copay
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$150 copay copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay per visit
Inpatient Hospital Stay	$500 copay per admission
Outpatient Surgery (Physician/Surgeon Fee) In-Network	150 copay at Physicians Office, $500 copay at Hospital
Outpatient Rehabilitation/Therapy In-Network	$50 copay
Mental/Behavioral Inpatient Services In-Network	$500 copay
Mental/Behavioral Outpatient Services In- Network	$25 copay
Chiropractic Services In-Network	$50 copay
Durable Medical Equipment	No Charge (Precertification required for items over $500)
Outpatient Surgery (Facility Fee) In-Network	$150 copay
Emergency/Urgent Care	
Emergency Room In-Network	$750 copay
Urgent care (NON-emergency room care) In-Network	$50 copay
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded)
Tier 2 Drug	$50 copay (after ded)
Tier 3 Drug	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Liberty Gold EPO 30/60 G
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$1,250
Annual Plan Year Deductible In-Network - Family	$2,500
Annual Out-of-Pocket Maximum In-Network - Individual	$7,000
Annual Out-of-Pocket Maximum In-Network - Family	$14,000
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	$35 copay (after ded)
Radiology/Major Diagnostic Test In-network	$100 copay (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded)
Inpatient Hospital Stay	$500 copay/day ($2000 max) (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$60 copay/visit (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	$500 copay/day ($2000 max) (after ded)
Mental/Behavioral Outpatient Services In- Network	$30 copay per visit; No Charge after ded. (partial hospitalization)
Chiropractic Services In-Network	$60 copay
Durable Medical Equipment	0% Coinsurance (after ded) (Precertification required for items over $500)
Outpatient Surgery (Facility Fee) In-Network	$150 copay at Physician Office(after ded), $250 copay at Hospital (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (not subject to ded)
Urgent care (NON-emergency room care) In-Network	$75 copay (not subjet to ded)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded)
Tier 2 Drug	$50 copay (after ded)
Tier 3 Drug	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Liberty Gold HSA 1600 M
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$1,600
Annual Plan Year Deductible In-Network - Family	$3,200
Annual Out-of-Pocket Maximum In-Network - Individual	$5,750
Annual Out-of-Pocket Maximum In-Network - Family	$11,500
Cost Sharing	
Primary Care Visit In-Network	10% Coinsurance (after ded)
Specialist Visit In-Network	10% Coinsurance (after ded)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	10% Coinsurance (after ded)
Diagnostic X-Rays In-Network	10% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	10% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	10% Coinsurance (after ded)
Inpatient Hospital Stay	10% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	10% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	10% Coinsurance (after ded)
Mental/Behavioral Inpatient Services In-Network	10% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	10% Coinsurance (after ded)
Chiropractic Services In-Network	10% Coinsurance (after ded)
Durable Medical Equipment	10% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	10% Coinsurance (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	10% Coinsurance (after ded)
Ambulance	10% Coinsurance (after ded)
Prescription Drugs	
Tier 1 Drug	$10 copay (after ded)
Tier 2 Drug	$50 copay (after ded)
Tier 3 Drug	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	Combined w/Medical
Annual Prescription Drug Deductible Family	Combined w/Medical

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Liberty Gold EPO 30/60
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$1,800
Annual Plan Year Deductible In-Network - Family	$3,600
Annual Out-of-Pocket Maximum In-Network - Individual	$8,000
Annual Out-of-Pocket Maximum In-Network - Family	$16,000
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	30% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	30% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded)
Inpatient Hospital Stay	30% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	30% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$60 copay (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	30% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$30 copay (not subject to ded)
Chiropractic Services In-Network	$60 copay (not subject to ded)
Durable Medical Equipment	30% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	30% Coinsurance (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (not subject to ded)
Urgent care (NON-emergency room care) In-Network	$75 copay (not subject to ded)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded)
Tier 2 Drug	$50 copay (after ded)
Tier 3 Drug	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Metro Gold EPO 25/40
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$1,250
Annual Plan Year Deductible In-Network - Family	$2,500
Annual Out-of-Pocket Maximum In-Network - Individual	$6,500
Annual Out-of-Pocket Maximum In-Network - Family	$13,000
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) - 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	20% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$60 copay/visit (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$25 copay/visit (not subject to ded)
Chiropractic Services In-Network	$40 copay (not subject to ded)
Durable Medical Equipment	20% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	$200 copay at Physicians Office (after ded), $500 copay at Hospital (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (not subject to ded)
Urgent care (NON-emergency room care) In-Network	$65 copay (not subject to ded)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded)
Tier 2 Drug	$65 copay (after ded)
Tier 3 Drug	$95 copay (after ded)
Annual Prescription Drug Deductible Individual	$150 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$150 Deductible/member

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

HealthPass℠ BENEFITS EXCHANGE

2023 Summary of Benefits

	Oxford Metro Gold EPO 25/40 G
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$1,250
Annual Plan Year Deductible In-Network - Family	$2,500
Annual Out-of-Pocket Maximum In-Network - Individual	$6,500
Annual Out-of-Pocket Maximum In-Network - Family	$13,000
Cost Sharing	
Primary Care Visit In-Network	$25 copay (not subject to ded)
Specialist Visit In-Network	$40 copay (not subject to ded)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	No Charge (Designated Diagnostic Provider) 50% Coinsurance after ded. (Non-Designated Diagnostic Provider)
Diagnostic X-Rays In-Network	$50 copay (after ded)
Radiology/Major Diagnostic Test In-network	$150 copay (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	20% Coinsurance (after ded)
Inpatient Hospital Stay	20% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	20% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$40 copay (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$25 copay (not subject to ded)
Chiropractic Services In-Network	$40 copay (not subject to ded)
Durable Medical Equipment	20% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	$200 copay at Physicians Office (after ded), $500 copay at Hospital (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (not subject to ded)
Urgent care (NON-emergency room care) In-Network	$65 copay (not subject to ded)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded)
Tier 2 Drug	$65 copay (after ded)
Tier 3 Drug	$95 copay (after ded)
Annual Prescription Drug Deductible Individual	$150 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$150 Deductible/member

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Anthem 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	$9,450
Annual Out-of-Pocket Maximum In-Network - Family	$18,900
Cost Sharing	
Primary Care Visit In-Network	$40 copay (ded does not apply)
Specialist Visit In-Network	$80 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	$80 copay (ded does not apply)
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% coinusrance (after ded)
Urgent care (NON-emergency room care) In-Network	$80 copay (ded does not apply)
Ambulance	50% coinsurance (after ded)
Prescription Drugs	
Tier 1 Drug	$25 copay
Tier 2 Drug	$75 copay
Tier 3 Drug	$90 copay
Annual Prescription Drug Deductible Individual	$200 Deductible
Annual Prescription Drug Deductible Family	$400 Deductible

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Anthem Silver EPO HSA 4000
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	$8,000
Annual Out-of-Pocket Maximum In-Network - Family	$16,000
Cost Sharing	
Primary Care Visit In-Network	$20 copay
Specialist Visit In-Network	$50 copay
OB/GYN Preventive Care In-Network	No charge
Diagnostic Lab Work In-Network	$25 copay
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Inpatient Hospital Stay	$1,500 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Outpatient Rehabilitation/Therapy In-Network	$50 copay
Mental/Behavioral Inpatient Services In-Network	$1,500 copay
Mental/Behavioral Outpatient Services In- Network	$20 copay
Chiropractic Services In-Network	$50 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$500 copay
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay
Urgent care (NON-emergency room care) In-Network	$100 copay
Ambulance	$500 copay
Prescription Drugs	
Tier 1 Drug	$10 copay
Tier 2 Drug	$50 copay
Tier 3 Drug	$90 copay
Annual Prescription Drug Deductible Individual	Combined with In-Network medical deductible
Annual Prescription Drug Deductible Family	Combined with In-Network out-of-pocket limit

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Anthem Silver EPO HSA 3250
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	$8,000
Annual Out-of-Pocket Maximum In-Network - Family	$16,000
Cost Sharing	
Primary Care Visit In-Network	$20 copay
Specialist Visit In-Network	$50 copay
OB/GYN Preventive Care In-Network	No charge
Diagnostic Lab Work In-Network	$25 copay
Diagnostic X-Rays In-Network	$50 copay
Radiology/Major Diagnostic Test In-network	$250 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Inpatient Hospital Stay	$1,500 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance
Outpatient Rehabilitation/Therapy In-Network	$50 copay
Mental/Behavioral Inpatient Services In-Network	$1,500 copay
Mental/Behavioral Outpatient Services In- Network	$20 copay
Chiropractic Services In-Network	$50 copay
Durable Medical Equipment	50% coinsurance
Outpatient Surgery (Facility Fee) In-Network	$500 copay
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay
Urgent care (NON-emergency room care) In-Network	$100 copay
Ambulance	$500 copay
Prescription Drugs	
Tier 1 Drug	$10 copay
Tier 2 Drug	$50 copay
Tier 3 Drug	$90 copay
Annual Prescription Drug Deductible Individual	Combined with In-Network medical deductible
Annual Prescription Drug Deductible Family	Combined with In-Network out-of-pocket limit

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Anthem Blue Access Silver EPO 30/75
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	$9,450
Annual Out-of-Pocket Maximum In-Network - Family	$18,900
Cost Sharing	
Primary Care Visit In-Network	$30 copay (ded does not apply)
Specialist Visit In-Network	$75 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	$30 copay (ded does not apply)
Mental/Behavioral Inpatient Services In-Network	50% coinsurance
Mental/Behavioral Outpatient Services In- Network	$30 copay (ded does not apply)
Chiropractic Services In-Network	$75 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	$75 copay (ded does not apply)
Ambulance	50% coinsurance
Prescription Drugs	
Tier 1 Drug	$25 copay
Tier 2 Drug	$75 copay
Tier 3 Drug	$90 copay
Annual Prescription Drug Deductible Individual	$200 does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$400 does not apply to Tier 1 drugs

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Anthem Connection 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	$9,450
Annual Out-of-Pocket Maximum In-Network - Family	$18,900
Cost Sharing	
Primary Care Visit In-Network	$40 copay (ded does not apply)
Specialist Visit In-Network	$80 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	$80 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	$80 copay (ded does not apply)
Ambulance	50% coinsurance
Prescription Drugs	
Tier 1 Drug	$25 copay
Tier 2 Drug	$75 copay
Tier 3 Drug	$90 copay
Annual Prescription Drug Deductible Individual	$200 does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$400 does not apply to Tier 1 drugs

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

HealthPass BENEFITS EXCHANGE

2024 Summary of Benefits

	EmblemHealth Select Care Silver Premier	
Deductible/Out-of-Pocket Max		
Annual Plan Year Deductible In-Network - Individual	$5,600	$8,000
Annual Plan Year Deductible In-Network - Family	$11,200	$16,000
Annual Out-of-Pocket Maximum In-Network - Individual	$9,400	$18,000
Annual Out-of-Pocket Maximum In-Network - Family	$18,800	$36,000
Cost Sharing		
Primary Care Visit In-Network	First visit, free. Thereafter, $35 copay (not subject to ded)	50% coinsurance (after ded)
Specialist Visit In-Network	$75 copay (not subject to ded)	50% coinsurance (after ded)
OB/GYN Preventive Care In-Network	No Charge	50% coinsurance (after ded)
Diagnostic Lab Work In-Network	$35 (PCP)/$75 (Specialist) copay (not subject to ded)	50% coinsurance (after ded)
Diagnostic X-Rays In-Network	$35 (PCP)/$75 (Specialist) copay (after ded)	50% coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	$75 copay (after ded)	50% coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$450 copay (after ded)	50% coinsurance (after ded)
Inpatient Hospital Stay	40% Coinsurance, per admission (after ded)	50% coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$450 copay (after ded)	50% coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$35 (PCP)/$75 (Specialist) copay (after ded)	Not Covered
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance, per admission (after ded)	50% coinsurance per admission (after ded)
Mental/Behavioral Outpatient Services In- Network	First visit, free. Thereafter, $35 copay (not subject to ded)	50% coinsurance (after ded)
Chiropractic Services In-Network	$75 copay (not subject to ded)	50% coinsurance (after ded)
Durable Medical Equipment	30% Coinsurance (after ded)	Not Covered
Outpatient Surgery (Facility Fee) In-Network	$450 copay (after ded)	50% coinsurance (after ded)
Emergency/Urgent Care		
Emergency Room In-Network	40% coinsurance (after ded)	40% coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded)	50% coinsurance (after ded)
Ambulance	$450 copayment (after ded)	$450 copayment (after ded)
Prescription Drugs		
Tier 1 Drug	$20 copay	Not Covered
Tier 2 Drug	$40 copay	Not Covered
Tier 3 Drug	$100 copay	Not Covered
Annual Prescription Drug ded Individual	$250 ded	N/A
Annual Prescription Drug Deductible Family	$500 ded	N/A

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	EmblemHealth Select Care 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	$7,500
Annual Out-of-Pocket Maximum In-Network - Family	$15,000
Cost Sharing	
Primary Care Visit In-Network	$30 copay (after ded)
Specialist Visit In-Network	$50 copay (after ded)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$30 (PCP)/$50 (Specialist) copay (after ded)
Diagnostic X-Rays In-Network	$30 (PCP)/$50 (Specialist) copay (after ded)
Radiology/Major Diagnostic Test In-network	$50 copay (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$450 copay (after ded)
Inpatient Hospital Stay	40% Coinsurance, per admission (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$450 copay (after ded)
Outpatient Rehabilitation/Therapy In-Network	$30 (PCP)/$50 (Specialist) copay (after ded)
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance, per admission (after ded)
Mental/Behavioral Outpatient Services In- Network	$30 copay (after ded)
Chiropractic Services In-Network	$50 copay (after ded)
Durable Medical Equipment	30% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	$450 copay (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	40% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded)
Ambulance	$450 copay (after ded)
Prescription Drugs	
Tier 1 Drug	$15 copay (after ded)
Tier 2 Drug	$45 copay (after ded)
Tier 3 Drug	$85 copay (after ded)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Liberty Silver EPO 50/100 ZD
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$9,450
Annual Out-of-Pocket Maximum In-Network - Family	$18,900
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	$200 copay
Radiology/Major Diagnostic Test In-network	$300 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$1,400 copay
Inpatient Hospital Stay	$2,800 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$150 copay Physician's Office, $250 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	$250 copay Physician's Office, $500 copay Hospital Setting
Emergency/Urgent Care	
Emergency Room In-Network	$1,500 copay
Urgent care (NON-emergency room care) In-Network	$100 copay
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$15 copay (not subject to ded)
Tier 2 Drug	$65 copay (after ded)
Tier 3 Drug	$95 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member
Annual Prescription Drug Deductible Family	$200 Deductible/member

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

HealthPass℠ / BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Liberty Silver EPO 40/80
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$3,250
Annual Plan Year Deductible In-Network - Family	$6,500
Annual Out-of-Pocket Maximum In-Network - Individual	$9,450
Annual Out-of-Pocket Maximum In-Network - Family	$18,900
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 does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$200 Deductible/member does not apply to Tier 1 drugs

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

HealthPass℠ / BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Liberty Silver EPO 30/60 G
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$4,500
Annual Plan Year Deductible In-Network - Family	$9,000
Annual Out-of-Pocket Maximum In-Network - Individual	$9,450
Annual Out-of-Pocket Maximum In-Network - Family	$18,900
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 does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$200 Deductible/member does not apply to Tier 1 drugs

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

2024 Summary of Benefits

	Oxford Liberty Silver HSA 4000 M
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$4,000
Annual Plan Year Deductible In-Network - Family	$8,000
Annual Out-of-Pocket Maximum In-Network - Individual	$8,000
Annual Out-of-Pocket Maximum In-Network - Family	$16,000
Cost Sharing	
Primary Care Visit In-Network	20% Coinsurance (after ded)
Specialist Visit In-Network	20% Coinsurance (after ded)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	20% Coinsurance (after ded)
Diagnostic X-Rays In-Network	20% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	20% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	20% Coinsurance (after ded)
Inpatient Hospital Stay	20% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	20% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	20% Coinsurance (after ded)
Mental/Behavioral Inpatient Services In-Network	20% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	20% Coinsurance (after ded)
Chiropractic Services In-Network	20% Coinsurance (after ded)
Durable Medical Equipment	20% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	20% Coinsurance (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	20% Coinsurance (after ded)
Ambulance	20% Coinsurance (after ded)
Prescription Drugs	
Tier 1 Drug	$10 copay (after ded)
Tier 2 Drug	$50 copay (after ded)
Tier 3 Drug	$90 copay (after ded)
Annual Prescription Drug Deductible Individual	Combined w/Medical
Annual Prescription Drug Deductible Family	Combined w/Medical

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Metro Silver EPO 50/100 ZD
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$9,450
Annual Out-of-Pocket Maximum In-Network - Family	$18,900
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	$200 copay
Radiology/Major Diagnostic Test In-network	$300 copay
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$1400 copay
Inpatient Hospital Stay	$2800 copay
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$125 copay at Physicians Office, $250 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	$250 copay at Physicians Office, $500 copay at Hospital
Emergency/Urgent Care	
Emergency Room In-Network	$1,500 copay
Urgent care (NON-emergency room care) In-Network	$100 copay
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$15 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 does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$200 Deductible/member does not apply to Tier 1 drugs

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

HealthPass℠ / BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Metro Silver EPO 30/80 G
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$3,750
Annual Plan Year Deductible In-Network - Family	$7,500
Annual Out-of-Pocket Maximum In-Network - Individual	$9,450
Annual Out-of-Pocket Maximum In-Network - Family	$18,900
Cost Sharing	
Primary Care Visit In-Network	$30 copay (not subject to ded)
Specialist Visit In-Network	$80 copay (not subject to ded)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	50% Coinsurance (after ded)
Diagnostic X-Rays In-Network	40% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	40% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	40% Coinsurance (after ded)
Inpatient Hospital Stay	40% Coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	40% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	$80 copay (not subject to ded)
Mental/Behavioral Inpatient Services In-Network	40% Coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	$30 copay (not subject to ded)
Chiropractic Services In-Network	$80 copay (not subject to ded)
Durable Medical Equipment	40% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	40% Coinsurance (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$80 copay (not subject to ded)
Ambulance	No Charge
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded)
Tier 2 Drug	$65 copay (after ded)
Tier 3 Drug	$95 copay (after ded)
Annual Prescription Drug Deductible Individual	$200 Deductible/member does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$200 Deductible/member does not apply to Tier 1 drugs

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

HealthPass℠ / BENEFITS EXCHANGE

2024 Summary of Benefits

	EmblemHealth Select Care Bronze HSA
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$7,400
Annual Plan Year Deductible In-Network - Family	$14,800
Annual Out-of-Pocket Maximum In-Network - Individual	$8,000
Annual Out-of-Pocket Maximum In-Network - Family	$16,000
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	30% Coinsurance (after ded)
Diagnostic X-Rays In-Network	30% Coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	50% Coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded)
Inpatient Hospital Stay	50% Coinsurance, per admission (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% Coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	50% Coinsurance (after ded)
Mental/Behavioral Inpatient Services In-Network	50% Coinsurance, per admission (after ded)
Mental/Behavioral Outpatient Services In- Network	50% Coinsurance (after ded)
Chiropractic Services In-Network	50% Coinsurance (after ded)
Durable Medical Equipment	50% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded)
Ambulance	50% Coinsurance (after ded)
Prescription Drugs	
Tier 1 Drug	$35 copay (after ded)
Tier 2 Drug	$65 copay (after ded)
Tier 3 Drug	$115 copay (after ded)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

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

HealthPass℠ BENEFITS EXCHANGE

2023 Summary of Benefits

	EmblemHealth Select Care Bronze Premier
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$7,100
Annual Plan Year Deductible In-Network - Family	$14,200
Annual Out-of-Pocket Maximum In-Network - Individual	$9,450
Annual Out-of-Pocket Maximum In-Network - Family	$18,900
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	30% Coinsurance (after ded)
Diagnostic X-Rays In-Network	30% 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	Thereafter, office visits: 50% Coinsurance (after ded)
Chiropractic Services In-Network	50% Coinsurance (after ded)
Durable Medical Equipment	50% Coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	50% Coinsurance (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	50% Coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	50% Coinsurance (after ded)
Ambulance	50% Coinsurance (after ded)
Prescription Drugs	
Tier 1 Drug	$50 copay (not subject to ded)
Tier 2 Drug	50% Coinsurance (after ded)
Tier 3 Drug	50% Coinsurance (after ded)
Annual Prescription Drug Deductible Individual	Combined w/ Medical
Annual Prescription Drug Deductible Family	Combined w/ Medical

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

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Liberty Bronze HSA 5750
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$5,750
Annual Plan Year Deductible In-Network - Family	$11,500
Annual Out-of-Pocket Maximum In-Network - Individual	$8,000
Annual Out-of-Pocket Maximum In-Network - Family	$16,000
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.

HealthPass℠ BENEFITS EXCHANGE

2024 Summary of Benefits

	Oxford Metro Bronze HSA 7250 G
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$7,250
Annual Plan Year Deductible In-Network - Family	$14,500
Annual Out-of-Pocket Maximum In-Network - Individual	$7,250
Annual Out-of-Pocket Maximum In-Network - Family	$14,500
Cost Sharing	
Primary Care Visit In-Network	0% coinsurance (after ded)
Specialist Visit In-Network	0% coinsurance (after ded)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	0% coinsurance (after ded)
Diagnostic X-Rays In-Network	0% coinsurance (after ded)
Radiology/Major Diagnostic Test In-network	0% coinsurance (after ded)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded)
Inpatient Hospital Stay	0% coinsurance (after ded)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded)
Outpatient Rehabilitation/Therapy In-Network	0% coinsurance (after ded)
Mental/Behavioral Inpatient Services In-Network	0% coinsurance (after ded)
Mental/Behavioral Outpatient Services In- Network	0% coinsurance (after ded)
Chiropractic Services In-Network	0% coinsurance (after ded)
Durable Medical Equipment	0% coinsurance (after ded)
Outpatient Surgery (Facility Fee) In-Network	0% coinsurance (after ded)
Emergency/Urgent Care	
Emergency Room In-Network	0% coinsurance (after ded)
Urgent care (NON-emergency room care) In-Network	0% coinsurance (after ded)
Ambulance	0% coinsurance (after ded)
Prescription Drugs	
Tier 1 Drug	0% coinsurance (after ded)
Tier 2 Drug	0% coinsurance (after ded)
Tier 3 Drug	0% coinsurance (after ded)
Annual Prescription Drug Deductible Individual	Combined w/Medical
Annual Prescription Drug Deductible Family	Combined w/Medical

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