HealthPass 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 office /$150 outpatient hospital
Radiology/Major Diagnostic Test In-network	$150 office/$250 outpatient hospital
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	$100 Deductible does not apply to Tier 1 drugs
Annual Prescription Drug Deductible Family	$200 Deductible does not apply to Tier 1 drugs

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

HealthPass BENEFITS EXCHANGE

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 office/ $150 outpatient hospital
Radiology/Major Diagnostic Test In-network	$150 office/ $250 outpatient hospital
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
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 (not subject to ded.)
Tier 2 Drug	$35 copay (after ded.)
Tier 3 Drug	$70 copay (after ded.)
Annual Prescription Drug Deductible Individual	$100 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

	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 (after ded.)	50% coinsurance (after ded.)
Diagnostic X-Rays In-Network	$10 (PCP)/$35 (Specialist) copay (after ded.)	50% coinsurance (after ded.)
Radiology/Major Diagnostic Test In-network	$35 (PCP)/$75 (Specialist) copay (after ded.)	50% coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay (after ded.)	50% coinsurance (after ded.)
Inpatient Hospital Stay	20% coinsurance/admission (after ded.)	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/admission (after ded.)	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 subject to ded.)	Not Covered
Tier 2 Drug	$30 copay (after ded.)	Not Covered
Tier 3 Drug	$65 copay (after ded.)	Not Covered
Annual Prescription Drug Deductible Individual	$100 Deductible/member (N/A Tier 1)	N/A
Annual Prescription Drug Deductible Family	$200 Deductible/member (N/A Tier 1)	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 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/admission (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/admission (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.

HealthPass BENEFITS EXCHANGE

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 (not subject to ded.)
Specialist Visit In-Network	$55 copay (not subject to ded.)
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	$150 office/ $250 outpatient hospital
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Inpatient Hospital Stay	$500 copay/admission (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$50 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	$500 copay/admission (after ded.)
Mental/Behavioral Outpatient Services In- Network	$50 copay (not subject to ded.)
Chiropractic Services In-Network	$55 copay (after ded.)
Durable Medical Equipment	50% coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$300 copay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (after ded.)
Urgent care (NON-emergency room care) In-Network	$60 copay (not subject to ded.)
Ambulance	0% coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$40 copay (after ded.)
Tier 3 Drug	$80 copay (after ded.)
Annual Prescription Drug Deductible Individual	$150 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$300 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

	Anthem Connection Gold EPO 25/50
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$0
Annual Plan Year Deductible In-Network - Family	$0
Annual Out-of-Pocket Maximum In-Network - Individual	$8,700
Annual Out-of-Pocket Maximum In-Network - Family	$17,400
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 office/ $150 outpatient hospital
Radiology/Major Diagnostic Test In-network	$150 office/ $250 outpatient hospial
Inpatient Surgery (Physician/Surgeon Fee) In-Network	No Charge
Inpatient Hospital Stay	$500 copay/admission
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$25 copay
Outpatient Rehabilitation/Therapy In-Network	$25 copay
Mental/Behavioral Inpatient Services In-Network	$500 copay/admission
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 (not subject to ded.)
Tier 2 Drug	$65 copay (after ded.)
Tier 3 Drug	$90 copay (after ded.)
Annual Prescription Drug Deductible Individual	$150 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$300 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

	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 (not subject to ded.)
Specialist Visit In-Network	$55 copay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	No Charge
Diagnostic X-Rays In-Network	$50 office/ $150 outpatient hospital
Radiology/Major Diagnostic Test In-network	$150 office/ $250 outpatient hospital
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Inpatient Hospital Stay	$500 copay/admission (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$50 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	$500 copay/admission (after ded.)
Mental/Behavioral Outpatient Services In- Network	$50 copay (not subject to ded.)
Chiropractic Services In-Network	$55 copay (aftet ded.)
Durable Medical Equipment	50% coinsurance (aftet ded.)
Outpatient Surgery (Facility Fee) In-Network	$300 copay (aftet ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (aftet ded.)
Urgent care (NON-emergency room care) In-Network	$60 copay (not subject to ded.)
Ambulance	0% coinsurance (aftet ded.)
Prescription Drugs	
Tier 1 Drug	$10 copay (not subject to ded.)
Tier 2 Drug	$40 copay (after ded.)
Tier 3 Drug	$80 copay (after ded.)
Annual Prescription Drug Deductible Individual	$150 Deductible/member (N/A Tier 1)
Annual Prescription Drug Deductible Family	$300 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

	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/admission (after ded.)	50% coinsurance/admission (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/admission (after ded.)	50% coinsurance/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 copay (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 Deductible/member (N/A Tier 1)	N/A
Annual Prescription Drug Dedctible Family	$300 Deductible/member (N/A Tier 1)	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
Inpatient Surgery (Physician/Surgeon Fee) In-Network	$250 copay/visit
Inpatient Hospital Stay	$500 copay/admission
Outpatient Surgery (Physician/Surgeon Fee) In-Network	$150 copay (Physician's Office), $500 copay (Hospital)
Outpatient Rehabilitation/Therapy In-Network	$50 copay
Mental/Behavioral Inpatient Services In-Network	$500 copay/admission
Mental/Behavioral Outpatient Services In- Network	$25 copay
Chiropractic Services In-Network	$50 copay
Durable Medical Equipment	No Charge (Prior Authorization 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 (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/visit; No Charge (after ded.) (partial hospitalization)
Chiropractic Services In-Network	$60 copay
Durable Medical Equipment	0% coinsurance (after ded.) (Prior Authorization required for items over $500)
Outpatient Surgery (Facility Fee) In-Network	$150 copay (after ded.) (Physician's Office), $250 copay (after ded.) (Hopsital)
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/admission (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/admission (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/admission (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/admission (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.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	20% coinsurance (after ded.)
Inpatient Hospital Stay	20% coinsurance/admission (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	20% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$60 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	20% coinsurance/admission (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 (after ded.) (Physician's Office), $500 copay (after ded.) (Hopsital)
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 (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 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 (after ded.) (Physician), $500 copay (after ded.) (Hospital)
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 (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	$25 copay (ded does not apply)
Diagnostic X-Rays In-Network	$75 copay (after ded.)
Radiology/Major Diagnostic Test In-network	$150 office/50% coinsurance- outpatient hospital
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance (after ded.)
Inpatient Hospital Stay	50% coinsurance/admission (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$40 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	50% coinsurance/admission (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	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 (not subject to ded.)
Ambulance	50% coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$25 copay (not subject to ded.)
Tier 2 Drug	$75 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	$400 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

	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 (after ded.)
Specialist Visit In-Network	$50 copay (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$25 copay (after ded.)
Diagnostic X-Rays In-Network	$50 copay (after ded.)
Radiology/Major Diagnostic Test In-network	$150 office/ $250 outpatient hospital
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Inpatient Hospital Stay	$1,500 copay/admission (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$50 copay (after ded.)
Mental/Behavioral Inpatient Services In-Network	$1,500 copay/admission (after ded.)
Mental/Behavioral Outpatient Services In- Network	$20 copay (after ded.)
Chiropractic Services In-Network	$50 copay (after ded.)
Durable Medical Equipment	50% coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$500 copay
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (after ded.)
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded.)
Ambulance	$500 copay (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

	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 (after ded.)
Specialist Visit In-Network	$50 copay (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$25 copay (after ded.)
Diagnostic X-Rays In-Network	$50 copay (after ded.)
Radiology/Major Diagnostic Test In-network	$150 office/ $250 outpatient hospital
Inpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Inpatient Hospital Stay	$1,500 copay/admission (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	0% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$50 copay (after ded.)
Mental/Behavioral Inpatient Services In-Network	$1,500 copay/admission (after ded.)
Mental/Behavioral Outpatient Services In- Network	$20 copay (after ded.)
Chiropractic Services In-Network	$50 copay (after ded.)
Durable Medical Equipment	50% coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$500 copay (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay (after ded.)
Urgent care (NON-emergency room care) In-Network	$100 copay (after ded.)
Ambulance	$500 copay (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

	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 (not subject to ded.)
Specialist Visit In-Network	$75 copay (not subject to ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	$20 copay (not subject to ded.)
Diagnostic X-Rays In-Network	$75 copay (after ded.)
Radiology/Major Diagnostic Test In-network	$150 office/ 50% coinsurance- outpatient hospital
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance (after ded.)
Inpatient Hospital Stay	50% coinsurance/admission (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$30 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	50% coinsurance/admission (after ded.)
Mental/Behavioral Outpatient Services In- Network	$30 copay (not subject to ded.)
Chiropractic Services In-Network	$75 copay (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	$75 copay (not subject to ded.)
Ambulance	50% coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$25 copay (not subject to ded.)
Tier 2 Drug	$75 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	$400 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

	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 (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	$20 copay (not subject to ded.)
Diagnostic X-Rays In-Network	$75 copay (after ded.)
Radiology/Major Diagnostic Test In-network	$150 office/ 50% coinsurance- outpatient hospital
Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance (after ded.)
Inpatient Hospital Stay	50% coinsurance/admission (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$40 copay (not subject to ded.)
Mental/Behavioral Inpatient Services In-Network	50% coinsurance/admission (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	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	50% coinsurance (after ded.)
Prescription Drugs	
Tier 1 Drug	$25 copay (not subject to ded.)
Tier 2 Drug	$75 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	$400 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

	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/admission (after ded.)	50% coinsurance/admission (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/admission (after ded.)	50% coinsurance/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 copay (after ded.)	$450 copay (after ded.)
Prescription Drugs		
Tier 1 Drug	$20 copay (not subject to ded.)	Not Covered
Tier 2 Drug	$40 copay (after ded.)	Not Covered
Tier 3 Drug	$100 copay (after ded.)	Not Covered
Annual Prescription Drug ded Individual	$250 Deductible/member (N/A Tier 1)	N/A
Annual Prescription Drug Deductible Family	$500 Deductible/member (N/A Tier 1)	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/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.

Health Pass 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/admission
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/admission
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 (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.

Health Pass 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/admission (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/admission (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 (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 Silver HSA 3000
Deductible/Out-of-Pocket Max	
Annual Plan Year Deductible In-Network - Individual	$3,000
Annual Plan Year Deductible In-Network - Family	$6,000
Annual Out-of-Pocket Maximum In-Network - Individual	$7,150
Annual Out-of-Pocket Maximum In-Network - Family	$14,300
Cost Sharing	
Primary Care Visit In-Network	$30 copay (after ded.)
Specialist Visit In-Network	$60 copay (after ded.)
OB/GYN Preventive Care In-Network	No Charge
Diagnostic Lab Work In-Network	20% coinsurance (after ded.)
Diagnostic X-Rays In-Network	$90 copay (after ded.)
Radiology/Major Diagnostic Test In-network	0% coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	20% coinsurance (after ded.)
Inpatient Hospital Stay	20% coinsurance/admission (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network	20% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network	$60 copay (after ded.)
Mental/Behavioral Inpatient Services In-Network	20% coinsurance/admission (after ded.)
Mental/Behavioral Outpatient Services In- Network	$30 copay (after ded.)
Chiropractic Services In-Network	$60 copay (after ded.)
Durable Medical Equipment	20% coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network	$150 in office/$250 in hospital (after ded.)
Emergency/Urgent Care	
Emergency Room In-Network	$500 copay
Urgent care (NON-emergency room care) In-Network	$75 copay
Ambulance	20% Coinsurance
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.

Health Pass 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/admission (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/admission (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 (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.

Health Pass BENEFITS EXCHANGE

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/admission (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/admission (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/admission
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/admission
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 (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 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/admission (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/admission (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 (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

	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/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/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

2024 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/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/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/admission (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/admission (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.

Health Pass 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.