

Anthem Platinum EPO 5/25
In-Network
\$0
\$0
\$3,700
\$7,400
\$5 copay
\$25 copay
No Charge
No Charge
\$50 office /\$150 outpatient hospital
\$150 office/\$250 outpatient hospital
\$5 copay
\$400 copay/admission
No Charge
\$5 copay
\$400 copay/admission
\$5 copay
\$25 copay
50% coinsurance
\$300 copay
\$300 copay
\$75 copay
\$300 copay
\$10 copay
\$35 copay
\$70 copay
\$100 Deductible does not apply to Tier 1 drugs
\$200 Deductible does not apply to Tier 1 drugs



	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.	



	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



Oxford Liberty Platinum EPO
\$500
\$1,000
\$2,450
\$4,900
\$5 copay/\$25 copay (not subject to ded.)
\$35 copay/\$70 copay (not subject to ded.)
No Charge
50% coinsurance (after ded.)
0% coinsurance (after ded.)
0% coinsurance (after ded.)
0% coinsurance (after ded.)
0% coinsurance/admission (after ded.)
0% Coinsurance (after ded.)
\$70 copay (not subject to ded.)
0% coinsurance/admission (after ded.)
\$5 copay (not subject to ded.)
\$35 copay (not subject to ded.)
0% coinsurance (after ded.)
0% coinsurance (after ded.)
\$250 copay (not subject to ded.)
\$75 copay (not subject to ded.)
No Charge
\$10 copay (not subject to ded.)
\$50 copay (after ded.)
\$90 copay (after ded.)
\$200 Deductible/member (N/A Tier 1)
\$200 Deductible/member (N/A Tier 1)



	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)
Annual Prescription Drug Deductible Family Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.	\$300 Deductible/member (N/A Her 1)



	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.	



	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.	. , , - ,



	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 Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.	\$300 Deductible/member (N/A Tier 1)	N/A



	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)



Oxford Liberty Gold EPO 30/60 G
\$1,250
\$2,500
\$7,000
\$14,000
\$30 copay (not subject to ded.)
\$60 copay (not subject to ded.)
No Charge
50% coinsurance (after ded.)
\$35 copay (after ded.)
\$100 copay (after ded.)
0% coinsurance (after ded.)
\$500 copay/day (\$2000 max) (after ded.)
0% coinsurance (after ded.)
\$60 copay (not subject to ded.)
\$500 copay/day (\$2000 max) (after ded.)
\$30 copay/visit; No Charge (after ded.) (partial hospitalization)
\$60 copay
0% coinsurance (after ded.) (Prior Authorization required for items over \$500)
\$150 copay (after ded.) (Physician's Office), \$250 copay (after ded.) (Hopsital)
\$500 copay (not subject to ded.)
\$75 copay (not subjet to ded.)
No Charge
\$10 copay (not subject to ded.)
\$50 copay (after ded.)
\$90 copay (after ded.)
\$200 Deductible/member (N/A Tier 1)
\$200 Deductible/member (N/A Tier 1)



	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



	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)



Oxford Metro Gold EPO 25/40
\$1,250
\$2,500
\$6,500
\$13,000
\$25 copay (not subject to ded.)
\$40 copay (not subject to ded.)
No Charge
No Charge (Designated Diagnostic Provider) 50% coinsurance (after ded.) (Non-Designated Diagnostic Provider)
\$50 copay (after ded.)
\$150 copay (after ded.)
20% coinsurance (after ded.)
20% coinsurance/admission (after ded.)
20% coinsurance (after ded.)
\$60 copay (not subject to ded.)
20% coinsurance/admission (after ded.)
\$25 copay (not subject to ded.)
\$40 copay (not subject to ded.)
20% coinsurance (after ded.)
\$200 copay (after ded.) (Physician's Office), \$500 copay (after ded.) (Hopsital)
\$500 copay (not subject to ded.)
\$65 copay (not subject to ded.)
No Charge
\$10 copay (not subject to ded.)
\$65 copay (after ded.)
\$95 copay (after ded.)
\$150 Deductible/member (N/A Tier 1)
\$150 Deductible/member (N/A Tier 1)



	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



	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.	7 2 ()



	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
Annual Prescription Drug Deductible Family Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.	Combined w/ Medical



Annual Plan Year Deductible In-Network - Individual Annual Plan Year Deductible In-Network - Family Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family Cost Sharing Primary Care Visit In-Network Specialist Visit In-Network	\$3,250 \$6,500 \$8,000 \$16,000
Annual Plan Year Deductible In-Network - Family Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family Cost Sharing Primary Care Visit In-Network	\$6,500 \$8,000
Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family Cost Sharing Primary Care Visit In-Network	\$8,000
Annual Out-of-Pocket Maximum In-Network - Family Cost Sharing Primary Care Visit In-Network	
Cost Sharing Primary Care Visit In-Network	\$16,000
Primary Care Visit In-Network	
Specialist Visit In-Network	\$20 copay (after ded.)
	\$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



Anthem Blue Access Silver EPO 30/75
\$4,550
\$9,100
\$9,450
\$18,900
\$30 copay (not subject to ded.)
\$75 copay (not subject to ded.)
No Charge
\$20 copay (not subject to ded.)
\$75 copay (after ded.)
\$150 office/ 50% coinsurance- outpatient hospital
50% coinsurance (after ded.)
50% coinsurance/admission (after ded.)
50% coinsurance (after ded.)
\$30 copay (not subject to ded.)
50% coinsurance/admission (after ded.)
\$30 copay (not subject to ded.)
\$75 copay (after ded.)
50% coinsurance (after ded.)
50% coinsurance (after ded.)
50% coinsurance (after ded.)
\$75 copay (not subject to ded.)
50% coinsurance (after ded.)
\$25 copay (not subject to ded.)
\$75 copay (after ded.)
\$90 copay (after ded.)
\$200 Deductible/member (N/A Tier 1)
\$400 Deductible/member (N/A Tier 1)



Annual Plan Year Deductible In-Network - Individual Annual Plan Year Deductible In-Network - Family Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family Cost Sharing Primary Care Visit In-Network Specialist Visit In-Network OB/GYN Preventive Care In-Network	\$3,250 \$6,500 \$9,450 \$18,900 \$40 copay (not subject to ded.) \$80 copay (not subject to ded.) No Charge \$20 copay (not subject to ded.) \$75 copay (after ded.) \$150 office/ 50% coinsurance- outpatient hospital 50% coinsurance (after ded.)
Annual Plan Year Deductible In-Network - Family Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family Cost Sharing Primary Care Visit In-Network Specialist Visit In-Network	\$6,500 \$9,450 \$18,900 \$40 copay (not subject to ded.) \$80 copay (not subject to ded.) No Charge \$20 copay (not subject to ded.) \$75 copay (after ded.)
Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family Cost Sharing Primary Care Visit In-Network Specialist Visit In-Network	\$9,450 \$18,900 \$40 copay (not subject to ded.) \$80 copay (not subject to ded.) No Charge \$20 copay (not subject to ded.) \$75 copay (after ded.) \$150 office/ 50% coinsurance- outpatient hospital
Annual Out-of-Pocket Maximum In-Network - Family Cost Sharing Primary Care Visit In-Network Specialist Visit In-Network	\$18,900 \$40 copay (not subject to ded.) \$80 copay (not subject to ded.) No Charge \$20 copay (not subject to ded.) \$75 copay (after ded.) \$150 office/ 50% coinsurance- outpatient hospital
Cost Sharing Primary Care Visit In-Network Specialist Visit In-Network	\$40 copay (not subject to ded.) \$80 copay (not subject to ded.) No Charge \$20 copay (not subject to ded.) \$75 copay (after ded.) \$150 office/ 50% coinsurance- outpatient hospital
Primary Care Visit In-Network Specialist Visit In-Network	\$80 copay (not subject to ded.) No Charge \$20 copay (not subject to ded.) \$75 copay (after ded.) \$150 office/ 50% coinsurance- outpatient hospital
Specialist Visit In-Network	\$80 copay (not subject to ded.) No Charge \$20 copay (not subject to ded.) \$75 copay (after ded.) \$150 office/ 50% coinsurance- outpatient hospital
	No Charge \$20 copay (not subject to ded.) \$75 copay (after ded.) \$150 office/ 50% coinsurance- outpatient hospital
OB/GYN Preventive Care In-Network	\$20 copay (not subject to ded.) \$75 copay (after ded.) \$150 office/ 50% coinsurance- outpatient hospital
	\$75 copay (after ded.) \$150 office/ 50% coinsurance- outpatient hospital
Diagnostic Lab Work In-Network	\$150 office/ 50% coinsurance- outpatient hospital
Diagnostic X-Rays In-Network	
Radiology/Major Diagnostic Test In-network	50% coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network	
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)



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



	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 Please refer to the official Summary of Receits and Coverage (SRC) for complete summary of coverage.	Combined w/ Medical



	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)



	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 Please refer to the official Summary of Renefits and Coverage (SRC) for complete summary of coverage.	\$200 Deductible/member (N/A Tier 1)



	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.	



	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 Please refer to the official Summary of Renefits and Coverage (SRC) for complete summary of coverage	\$200 Deductible/member (N/A Tier 1)



	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	unanananananananananananananananananana
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 Repetits and Coverage (SRC) for complete summary of coverage	



	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.	



	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)



Annual Plan Year Deductible In-Network - Individual \$7,400 Annual Plan Year Deductible In-Network - Individual \$5,400 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 \$15,000 Cost Sharing Primary Care Visit In-Network \$50% coinsurance (after ded.) Specials Visit In-Network \$50% coinsurance (after ded.) OB/GYN Preventive Care In-Network \$0% coinsurance (after ded.) Diagnostic Lab Work In-Network \$30% coinsurance (after ded.) 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.) Impatient Surgery (Physician/Surgeon Fee) In-Network \$50% coinsurance (after ded.) Impatient Hospital Stay \$50% coinsurance (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 (after ded.) Mental/Behavioral Outpatient Services In-Network \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) O		EmblemHealth Select Care Bronze HSA
Annual Plan Year Deductible In-Network - Family S14,800 Annual Out-of-Pocket Maximum In-Network - Individual Annual Out-of-Pocket Maximum In-Network - Family S16,000 Cost Sharing Primary Care Visit In-Network Specialist Visit	Deductible/Out-of-Pocket Max	
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.) Specialist Visit In-Network \$50% coinsurance (after ded.) Bignostic Lab Work In-Network \$50% coinsurance (after ded.) Diagnostic Lab Work In-Network \$50% coinsurance (after ded.) Diagnostic X-Rays In-Network \$50% coinsurance (after ded.) Madiology/Major Diagnostic Test In-network \$50% coinsurance (after ded.) Impatient Surgery (Physician/Surgeon Fee) In-Network \$50% coinsurance (after ded.) Impatient Hospital Stay \$50% coinsurance (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.) Mental/Behavioral Outpatient Services In-Network \$50% coinsurance (after ded.) Durable Medical Equipment \$50% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network \$50% coinsurance (after ded.) Durable Medical Equipment \$50% coinsurance (after ded.) Energency/Urgent Care Emergency/Urgent Care Emergency Room In-Network \$50% coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network \$50% coinsurance (after ded.) Prescription Drugs Tier 1 Drug \$55 copay (after ded.) Tier 2 Drug \$65 copay (after ded.) Annual Prescription Drug Deductible Individual \$50% coinsurance (Amedical \$50%	Annual Plan Year Deductible In-Network - Individual	\$7,400
Annual Out-of-Pocket Maximum In-Network - Family Cost Sharing Primary Care Visit In-Network Specialist Visit In-Network No Charge No Charge No Charge Specialist Visit In-Network Specialist Surger (Physician/Surgeon Fee) In-Network Specialist Surgery (Physician/Surgeon Fee) In-Network Specialist Speciali	Annual Plan Year Deductible In-Network - Family	\$14,800
Primary Care Visit In-Network Specialist Visit In-Network No Charge Diagnostic Lab Work In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network No Charge Diagnostic Lab Work In-Network Specialist Visit In-Network Specialist Visi	Annual Out-of-Pocket Maximum In-Network - Individual	\$8,000
Primary Care Visit In-Network Specialist Visit In-Network No Charge Diagnostic Lab Work In-Network Specialist Visit In-Network Specialist Surgery (Physician/Surgeon Fee) In-Network Specialist Surgery (Physician/Surgeon Fee) In-Network Specialist Spec	Annual Out-of-Pocket Maximum In-Network - Family	\$16,000
Specialist Visit In-Network Specialist Visit In-Network Specialist Visit In-Network No Charge Diagnostic Lab Work In-Network Diagnostic Lab Work In-Network Radiology/Major Diagnostic Test In-network So% coinsurance (after ded.) Inpatient Surgery (Physician/Surgeon Fee) In-Network So% coinsurance (after ded.) Inpatient Surgery (Physician/Surgeon Fee) In-Network So% coinsurance (after ded.) Outpatient Surgery (Physician/Surgeon Fee) In-Network So% coinsurance (after ded.) Outpatient Rehabilitation/Therapy In-Network So% coinsurance (after ded.) Outpatient Rehabilitation/Therapy In-Network So% coinsurance (after ded.) Mental/Behavioral Inpatient Services In-Network So% coinsurance (after ded.) Chiropractic Services In-Network So% coinsurance (after ded.) Durable Medical Equipment So% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network So% coinsurance (after ded.) Urgent Care Emergency/Urgent Care Emergency Room In-Network So% coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network So% coinsurance (after ded.) Prescription Drugs Tier 1 Drug Som coinsurance (after ded.) Tier 2 Drug Som coinsurance (after ded.) Tier 3 Drug Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Combined w/ Medical	Cost Sharing	
OB/GYN Preventive Care in-Network No Charge Diagnostic Lab Work in-Network Diagnostic X-Rays In-Network Radiology/Major Diagnostic Test In-network Biognostic X-Rays In-Network Radiology/Major Diagnostic Test In-network Inpatient Surgery (Physician/Surgeon Fee) In-Network Inpatient Surgery (Physician/Surgeon Fee) In-Network Inpatient Hospital Stay Sow coinsurance (after ded.) Outpatient Surgery (Physician/Surgeon Fee) In-Network Sow coinsurance (after ded.) Outpatient Surgery (Physician/Surgeon Fee) In-Network Sow coinsurance (after ded.) Outpatient Rehabilitation/Therapy In-Network Sow coinsurance (after ded.) Mental/Behavioral Inpatient Services In-Network Sow coinsurance (after ded.) Mental/Behavioral Outpatient Services In-Network Sow coinsurance (after ded.) Durable Medical Equipment Sow coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network Sow coinsurance (after ded.) Emergency/Urgent Care Emergency Room In-Network Sow coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network Sow coinsurance (after ded.) Prescription Drugs Tier 1 Drug Som coinsurance (after ded.) Sow coinsurance (after ded.) Tier 2 Drug Som coinsurance (after ded.) Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family	Primary Care Visit In-Network	50% coinsurance (after ded.)
Diagnostic Lab Work In-Network Diagnostic X-Rays In-Network Radiology/Major Diagnostic Test In-network Radiology/Major Diagnostic Test In-network Radiology/Major Diagnostic Test In-network Inpatient Surgery (Physician/Surgeon Fee) In-Network Duratient Hospital Stay Som coinsurance (after ded.) Outpatient Surgery (Physician/Surgeon Fee) In-Network Som coinsurance (after ded.) Outpatient Surgery (Physician/Surgeon Fee) In-Network Som coinsurance (after ded.) Outpatient Rehabilitation/Therapy In-Network Som coinsurance (after ded.) Mental/Behavioral Inpatient Services In-Network Som coinsurance (after ded.) Mental/Behavioral Outpatient Services In-Network Som coinsurance (after ded.) Durable Medical Equipment Som coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network Som coinsurance (after ded.) Urgent Care Emergency/Urgent Care Emergency/Urgent Care Emergency Room In-Network Som coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network Som coinsurance (after ded.) Prescription Drugs Tier 1 Drug Som coinsurance (after ded.) Som coinsurance (after ded.) Tier 2 Drug Som coinsurance (after ded.) Som coinsurance (after ded.) Tier 3 Drug Som coinsurance (after ded.) Combined w/ Medical Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family	Specialist Visit In-Network	50% coinsurance (after ded.)
Diagnostic X-Rays In-Network Radiology/Major Diagnostic Test In-network Som coinsurance (after ded.) Inpatient Surgery (Physician/Surgeon Fee) In-Network Som coinsurance (after ded.) Inpatient Hospital Stay Som coinsurance (after ded.) Outpatient Surgery (Physician/Surgeon Fee) In-Network Som coinsurance (after ded.) Outpatient Rehabilitation/Therapy In-Network Som coinsurance (after ded.) Outpatient Rehabilitation/Therapy In-Network Som coinsurance (after ded.) Mental/Behavioral Inpatient Services In-Network Som coinsurance (after ded.) Mental/Behavioral Outpatient Services In-Network Som coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network Som coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network Som coinsurance (after ded.) Emergency/Urgent Care Emergency/Urgent Care Emergency Room In-Network Som coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network Som coinsurance (after ded.) Prescription Drugs Tier 1 Drug Som coinsurance (after ded.) Tier 2 Drug Som coinsurance (after ded.) Som coinsurance (after ded.) Tier 3 Drug Som coinsurance (after ded.) Combined w/ Medical Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Combined w/ Medical	OB/GYN Preventive Care In-Network	No Charge
Radiology/Major Diagnostic Test In-network Inpatient Surgery (Physician/Surgeon Fee) In-Network Inpatient Hospital Stay Some coinsurance (after ded.) Outpatient Surgery (Physician/Surgeon Fee) In-Network Some coinsurance (after ded.) Outpatient Rehabilitation/Therapy In-Network Some coinsurance (after ded.) Outpatient Rehabilitation/Therapy In-Network Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Some coinsurance (after ded.) Chiropractic Services In-Network Some coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network Some coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network Some coinsurance (after ded.) Emergency/Urgent Care Emergency/Urgent Care Emergency Room In-Network Some coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network Some coinsurance (after ded.) Prescription Drugs Tier 1 Drug Some coinsurance (after ded.) Tier 2 Drug Some coinsurance (after ded.) Tier 3 Drug Some coinsurance (after ded.) Combined w/ Medical Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Combined w/ Medical	Diagnostic Lab Work In-Network	30% coinsurance (after ded.)
Inpatient Surgery (Physician/Surgeon Fee) In-Network Inpatient Hospital Stay So% coinsurance (after ded.) So% coinsurance (after ded.) Outpatient Surgery (Physician/Surgeon Fee) In-Network So% coinsurance (after ded.) Outpatient Rehabilitation/Therapy In-Network So% coinsurance (after ded.) Mental/Behavioral Inpatient Services In-Network So% coinsurance (after ded.) Mental/Behavioral Outpatient Services In-Network So% coinsurance (after ded.) Chiropractic Services In-Network So% coinsurance (after ded.) Outpatient Surgery (Facility Fee) In-Network So% coinsurance (after ded.) Durable Medical Equipment So% coinsurance (after ded.) Emergency/Urgent Care Emergency/Urgent Care Emergency Room In-Network So% coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network Som coinsurance (after ded.) Prescription Drugs Tier 1 Drug Som coinsurance (after ded.) Tier 2 Drug Som coinsurance (after ded.) Tier 3 Drug Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Combined w/ Medical	Diagnostic X-Rays In-Network	30% coinsurance (after ded.)
Inpatient Hospital Stay Outpatient Surgery (Physician/Surgeon Fee) In-Network Outpatient Rehabilitation/Therapy In-Network Som coinsurance (after ded.) Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Som coinsurance (after ded.) Mental/Behavioral Outpatient Services In-Network Som coinsurance (after ded.) Chiropractic Services In-Network Som coinsurance (after ded.) Durable Medical Equipment Outpatient Surgery (Facility Fee) In-Network Som coinsurance (after ded.) Emergency/Urgent Care Emergency Room In-Network Som coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network Som coinsurance (after ded.) Prescription Drugs Tier 1 Drug \$35 copay (after ded.) Tier 2 Drug \$65 copay (after ded.) Tier 3 Drug Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Combined w/ Medical	Radiology/Major Diagnostic Test In-network	50% coinsurance (after ded.)
Outpatient Surgery (Physician/Surgeon Fee) In-Network Outpatient Rehabilitation/Therapy In-Network Sow coinsurance (after ded.) Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Sow coinsurance (after ded.) Mental/Behavioral Outpatient Services In-Network Sow coinsurance (after ded.) Chiropractic Services In-Network Sow coinsurance (after ded.) Durable Medical Equipment Outpatient Surgery (Facility Fee) In-Network Sow coinsurance (after ded.) Emergency/Urgent Care Emergency Room In-Network Sow coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network \$100 copay (after ded.) Prescription Drugs Tier 1 Drug \$35 copay (after ded.) Tier 2 Drug \$65 copay (after ded.) Tier 3 Drug Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Combined w/ Medical	Inpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance (after ded.)
Outpatient Rehabilitation/Therapy In-Network Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Mental/Behavioral Outpatient Services In-Network 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.) Prescription Drugs Tier 1 Drug \$35 copay (after ded.) Tier 2 Drug \$65 copay (after ded.) Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Combined w/ Medical	Inpatient Hospital Stay	50% coinsurance/admission (after ded.)
Mental/Behavioral Inpatient Services In-Network Mental/Behavioral Outpatient Services In-Network Chiropractic Services In-Network Durable Medical Equipment Outpatient Surgery (Facility Fee) In-Network Emergency/Urgent Care Emergency Room In-Network Jow coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network Tier 1 Drug Tier 2 Drug Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Sow coinsurance/admission (after ded.) 50% coinsurance (after ded.)	Outpatient Surgery (Physician/Surgeon Fee) In-Network	50% coinsurance (after ded.)
Mental/Behavioral Outpatient Services In- Network Chiropractic Services In-Network Durable Medical Equipment Outpatient Surgery (Facility Fee) In-Network Emergency/Urgent Care Emergency Room In-Network So% coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network \$100 copay (after ded.) Prescription Drugs Tier 1 Drug \$35 copay (after ded.) Tier 2 Drug \$115 copay (after ded.) Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Combined w/ Medical	Outpatient Rehabilitation/Therapy In-Network	50% coinsurance (after ded.)
Chiropractic Services In-Network 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 \$35 copay (after ded.) Frescription Drugs Tier 1 Drug \$35 copay (after ded.) Tier 2 Drug \$65 copay (after ded.) Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Combined w/ Medical	Mental/Behavioral Inpatient Services In-Network	50% coinsurance/admission (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 Annual Prescription Drug Deductible Family Combined w/ Medical	Mental/Behavioral Outpatient Services In- Network	50% coinsurance (after ded.)
Outpatient Surgery (Facility Fee) In-Network Emergency/Urgent Care Emergency Room In-Network 50% coinsurance (after ded.) Urgent care (NON-emergency room care) In-Network Ambulance Prescription Drugs Tier 1 Drug \$35 copay (after ded.) Tier 2 Drug \$65 copay (after ded.) Tier 3 Drug Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Combined w/ Medical	Chiropractic Services In-Network	50% coinsurance (after ded.)
Emergency Room In-Network Emergency Room In-Network Urgent care (NON-emergency room care) In-Network Ambulance Prescription Drugs Tier 1 Drug \$35 copay (after ded.) Tier 2 Drug \$65 copay (after ded.) Tier 3 Drug Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family 50% coinsurance (after ded.) \$50% coinsurance (after ded.)	Durable Medical Equipment	50% coinsurance (after ded.)
Emergency Room In-Network Urgent care (NON-emergency room care) In-Network Ambulance Frescription Drugs Tier 1 Drug \$35 copay (after ded.) Tier 2 Drug \$65 copay (after ded.) Tier 3 Drug Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family 50% coinsurance (after ded.) \$50% coinsurance (after ded.)	Outpatient Surgery (Facility Fee) In-Network	50% coinsurance (after ded.)
Urgent care (NON-emergency room care) In-Network 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 Annual Prescription Drug Deductible Family Combined w/ Medical	Emergency/Urgent Care	
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 Annual Prescription Drug Deductible Family Combined w/ Medical	Emergency Room In-Network	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	Urgent care (NON-emergency room care) In-Network	\$100 copay (after ded.)
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	Ambulance	50% coinsurance (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	Prescription Drugs	
Tier 3 Drug \$115 copay (after ded.) Annual Prescription Drug Deductible Individual Combined w/ Medical Annual Prescription Drug Deductible Family Combined w/ Medical	Tier 1 Drug	\$35 copay (after ded.)
Annual Prescription Drug Deductible Individual Annual Prescription Drug Deductible Family Combined w/ Medical Combined w/ Medical	Tier 2 Drug	\$65 copay (after ded.)
Annual Prescription Drug Deductible Family Combined w/ Medical	Tier 3 Drug	\$115 copay (after ded.)
	Annual Prescription Drug Deductible Individual	Combined w/ Medical
		Combined w/ Medical



EmblemHealth Select Care Bronze Premier
\$7,100
\$14,200
\$9,450
\$18,900
First visit, free. Thereafter, 50% coinsurance (after ded.)
50% coinsurance (after ded.)
No Charge
30% coinsurance (after ded.)
30% coinsurance (after ded.)
50% coinsurance (after ded.)
50% coinsurance (after ded.)
50% coinsurance/admission (after ded.)
50% coinsurance (after ded.)
50% coinsurance (after ded.)
50% coinsurance/admission (after ded.)
Thereafter, office visits: 50% coinsurance (after ded.)
50% coinsurance (after ded.)
50% coinsurance (after ded.)
50% coinsurance (after ded.)
50% coinsurance (after ded.)
50% coinsurance (after ded.)
50% coinsurance (after ded.)
\$50 copay (not subject to ded.)
50% coinsurance (after ded.)
50% coinsurance (after ded.)
, ,
Combined w/ Medical



\$5,750
\$11,500
\$8,000
\$16,000
\$25 copay (after ded.)
\$75 copay (after ded.)
No Charge
30% coinsurance (after ded.)
30% coinsurance/admission (after ded.)
30% coinsurance (after ded.)
\$75 copay (after ded.)
30% coinsurance/admission (after ded.)
\$25 copay (after ded.)
\$75 copay (after ded.)
30% coinsurance (after ded.)
30% coinsurance (after ded.)
50% coinsurance (after ded.)
30% coinsurance (after ded.)
30% coinsurance (after ded.)
30% coinsurance (after ded.)
30% coinsurance (after ded.)
30% coinsurance (after ded.)
Combined w/Medical
Combined w/Medical



	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.	