2026 Summary of Benefits

2026 Summary of Benefits

Anthem Platinum EPO 5/25	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$3,900
OOP Max Family	$7,800
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$5
Specialist Visit Copay	$25
Outpatient Diagnostic Labs / X-Ray	$0 / $50
Outpatient Complex Imaging	$250
Physical / Occupational Therapy	$5
Inpatient Hospital	Facility: $400 / Physician: $0
Outpatient Surgery	Facility: $300 / Freestanding: $50 / Physician: $5
Durable Medical Equipment	50%
Emergency/Urgent Care	
Urgent Care Copay	$50
ER Copay	$300, waived if admitted
Ambulance	$300
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$100 individual/$200 family
Rx Retail	$10/$35/$70 after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Blue Access Platinum EPO 5/25	
Deductibles/Out-of-Pocket Max	
Deductible Individual (IN / OON)	$0 / N/A
Deductible Family (IN / OON)	$0 / N/A
OOP Max Individual (IN / OON)	$3,900 / N/A
OOP Max Family (IN / OON)	$7,800 / N/A
Coinsurance (IN / OON)	0% / N/A
Cost Sharing	
PCP Visit Copay	$5
Specialist Visit Copay	$25
Outpatient Diagnostic Labs / X-Ray	$0 / $50
Outpatient Complex Imaging	$250
Physical / Occupational Therapy	$5
Inpatient Hospital	Facility: $400 / Physician: $0
Outpatient Surgery	Facility: $300 / Freestanding: $50 / Physician: $5
Durable Medical Equipment	50%
Emergency/Urgent Care	
Urgent Care Copay	$50
ER Copay	$300, waived if admitted
Ambulance	$300
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$100 individual/$200 family
Rx Retail	$10/$35/$70 after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Connection Platinum EPO 20/40	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$3,500
OOP Max Family	$7,000
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$20
Specialist Visit Copay	$40
Outpatient Diagnostic Labs / X-Ray	$0 / $50
Outpatient Complex Imaging	$250
Physical / Occupational Therapy	$20
Inpatient Hospital	Facility: $500 / Physician: $0
Outpatient Surgery	Facility: $500 / Freestanding: $100 / Physician: $20
Durable Medical Equipment	50%
Emergency/Urgent Care	
Urgent Care Copay	$50
ER Copay	$300, waived if admitted
Ambulance	$300 per trip
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$100 individual/$200 family
Rx Retail	$10/$35/$70 after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Gold EPO 30/65 G	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,600
Deductible Family	$3,200
OOP Max Individual	$7,500
OOP Max Family	$15,000
Coinsurance	20%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$65
Outpatient Diagnostic Labs / X-Ray	$0 / $50 after deductible
Outpatient Complex Imaging	$300 after deductible
Physical / Occupational Therapy	$30
Inpatient Hospital	20% after deductible
Outpatient Surgery	Facility: $300 after deductible / Freestanding: $200 after deductible / Physician: 20% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$85
ER Copay	$500 after deductible, waived if admitted
Ambulance	20% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$200 individual/$400 family
Rx Retail	$10/$50/50% after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Blue Access Gold EPO 30/60	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$9,150
OOP Max Family	$18,300
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$60
Outpatient Diagnostic Labs / X-Ray	$0 / $100
Outpatient Complex Imaging	$250
Physical / Occupational Therapy	$30
Inpatient Hospital	Facility: $600 / Physician: $0
Outpatient Surgery	Facility: $500 / Freestanding: $300 / Physician: $30
Durable Medical Equipment	50%
Emergency/Urgent Care	
Urgent Care Copay	$90
ER Copay	$850, waived if admitted
Ambulance	$850
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	In Network: $200 individual/$400 family
Rx Retail	$10/$65/$100 after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Blue Access Gold EPO 50/60	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,200
Deductible Family	$2,400
OOP Max Individual	$7,000
OOP Max Family	$14,000
Coinsurance	10%
Cost Sharing	
PCP Visit Copay	$50
Specialist Visit Copay	$60
Outpatient Diagnostic Labs / X-Ray	$0 / 50% after deductible
Outpatient Complex Imaging	$250 after deductible
Physical / Occupational Therapy	$50
Inpatient Hospital	10% after deductible
Outpatient Surgery	Facility: $300 after deductible / Freestanding: $150 after deductible / Physician: 10% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
ER Copay	$750 after deductible, waived if admitted
Ambulance	10% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$150 individual/$300 family
Rx Retail	$10/$50/$90 after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Connection Gold EPO 30 65 G	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,600
Deductible Family	$3,200
OOP Max Individual	$7,500
OOP Max Family	$15,000
Coinsurance	20%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$65
Outpatient Diagnostic Labs / X-Ray	$0 / $50 after deductible
Outpatient Complex Imaging	$300 after deductible
Physical / Occupational Therapy	$30
Inpatient Hospital	20% after deductible
Outpatient Surgery	Facility: $300 after deductible / Freestanding: $200 after deductible / Physician: 20% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$85
ER Copay	$500 after deductible, waived if admitted
Ambulance	20% coinsurance
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$200 individual/$400 family
Rx Retail	$10/$50/50% after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Blue Access Gold EPO 30/65 G	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,600
Deductible Family	$3,200
OOP Max Individual	$7,500
OOP Max Family	$15,000
Coinsurance	20%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$65
Outpatient Diagnostic Labs / X-Ray	$0 / $50 deductible
Outpatient Complex Imaging	$300 after deductible
Physical / Occupational Therapy	$30
Inpatient Hospital	20% after deductible
Outpatient Surgery	Facility: $300 after deductible / Freestanding: $200 after deductible / Physician: 20% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$85
ER Copay	$500 after deductible, waived if admitted
Ambulance	20% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$200 individual/$400 family
Rx Retail	$10/$50/50% after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Connection Gold EPO 30/60	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$9,150
OOP Max Family	$18,300
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$60
Outpatient Diagnostic Labs / X-Ray	$0 / $100
Outpatient Complex Imaging	$250
Physical / Occupational Therapy	$30
Inpatient Hospital	Facility: $600 / Physician: $0
Outpatient Surgery	Facility: $500 / Freestanding: $300 / Physician: $30
Durable Medical Equipment	50%
Emergency/Urgent Care	
Urgent Care Copay	$90
ER Copay	$850, waived if admitted
Ambulance	$850 / trip
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$200 individual/$400 family
Rx Retail	$10/$65/$100 after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Connection Gold 50/60	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,200
Deductible Family	$2,400
OOP Max Individual	$7,000
OOP Max Family	$14,000
Coinsurance	10%
Cost Sharing	
PCP Visit Copay	$50
ER Copay	$750 after deductible, waived if admitted
Outpatient Diagnostic Labs / X-Ray	$0 / $50 after deductible
Outpatient Complex Imaging	$250 after deductible
Physical / Occupational Therapy	$50
Inpatient Hospital	10% after deductible
Outpatient Surgery	Facility: $300 after deductible / Freestanding: $150 after deductible / Physician: 10% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Specialist Visit Copay	$60
Urgent Care Copay	$100
Ambulance	10% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$150 individual/$300 family
Rx Retail	$10/$50/$90 after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem EPO Silver 40/80	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$3,450
Deductible Family	$6,900
OOP Max Individual	$9,700
OOP Max Family	$19,400
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$40
Specialist Visit Copay	$80
Outpatient Diagnostic Labs / X-Ray	$20 / $75
Outpatient Complex Imaging	50% after deductible
Physical / Occupational Therapy	$40
Inpatient Hospital	50% after deductible
Outpatient Surgery	Facility: 50% after deductible / Freestanding: $300 after deductible / Physician: 50% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	50% after deductible
Ambulance	50% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$200 individual/$400 family
Rx Retail	$25/$75/$90 after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem EPO Silver 40 80 G	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$3,450
Deductible Family	$6,900
OOP Max Individual	$9,700
OOP Max Family	$19,400
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$40
Specialist Visit Copay	$80
Outpatient Diagnostic Labs / X-Ray	$20 / $75
Outpatient Complex Imaging	50% after deductible
Physical / Occupational Therapy	$40
Inpatient Hospital	50% after deductible
Outpatient Surgery	Facility: 50% after deductible / Freestanding: $300 after deductible / Physician: 50% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	50% after deductible
Ambulance	50% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$200 individual/$400 family
Rx Retail	$25/$75/$90 after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

HealthPass BENEFITS EXCHANGE

Anthem

2026 Summary of Benefits

Anthem Silver EPO HSA 4100	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$4,100
Deductible Family	$8,200
OOP Max Individual	$8,450
OOP Max Family	$16,900
Coinsurance	30%
Cost Sharing	
PCP Visit Copay	$20 after deductible
Specialist Visit Copay	$50 after deductible
Outpatient Diagnostic Labs / X-Ray	30% after deductible
Outpatient Complex Imaging	30% after deductible
Physical / Occupational Therapy	30% after deductible
Inpatient Hospital	30% after deductible
Outpatient Surgery	30% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100 after deductible
ER Copay	30% after deductible
Ambulance	30% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	$10/$50/$90 after deductible
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Blue Access Silver EPO 35-80	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$4,650
Deductible Family	$9,300
OOP Max Individual	$9,700
OOP Max Family	$19,400
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$35
Specialist Visit Copay	$80
Outpatient Diagnostic Labs / X-Ray	$20 / $75
Outpatient Complex Imaging	50% after deductible
Physical / Occupational Therapy	$35
Inpatient Hospital	50% after deductible
Outpatient Surgery	Facility: 50% after deductible / Freestanding: $300 after deductible / Physician: 50% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	50% after deductible
Ambulance	50% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$200 individual/$400 family
Rx Retail	$20/$75/50% after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Blue Access Silver EPO 40/80 G	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$3,450
Deductible Family	$6,900
OOP Max Individual	$9,700
OOP Max Family	$19,400
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$40
Specialist Visit Copay	$80
Outpatient Diagnostic Labs / X-Ray	$20 / $75
Outpatient Complex Imaging	50% after deductible
Physical / Occupational Therapy	$40
Inpatient Hospital	50% after deductible
Outpatient Surgery	Facility: 50% after deductible / Freestanding: $300 after deductible / Physician: 50% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	50% after deductible
Ambulance	50% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$200 individual/$400 family
Rx Retail	$25/$75/$90 after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Blue Access Silver EPO HSA 3300	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$3,300
Deductible Family	$6,600
OOP Max Individual	$8,450
OOP Max Family	$16,900
Coinsurance	30%
Cost Sharing	
PCP Visit Copay	$30 after deductible
Specialist Visit Copay	$60 after deductible
Outpatient Diagnostic Labs / X-Ray	30% after deductible
Outpatient Complex Imaging	30% after deductible
Physical / Occupational Therapy	30% after deductible
Inpatient Hospital	30% after deductible
Outpatient Surgery	30% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100 after deductible
ER Copay	30% after deductible
Ambulance	30% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	$10/30%/50% after deductible
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Connection Silver EPO 40/80	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$3,450
Deductible Family	$6,900
OOP Max Individual	$9,700
OOP Max Family	$19,400
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$40
Specialist Visit Copay	$80
Outpatient Diagnostic Labs / X-Ray	$20 / $75
Outpatient Complex Imaging	50% after deductible
Physical / Occupational Therapy	$40
Inpatient Hospital	50% after deductible
Outpatient Surgery	Facility: 50% after deductible / Freestanding: $300 after deductible / Physician: 50% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	50% after deductible
Ambulance	50% coinsurance
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$225
Rx Retail	$25/$75/$90 after Rx deductible, does not apply to Tier 1
View Summary of Benefits of Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Connection Silver EPO 40 80 G	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$3,450
Deductible Family	$6,900
OOP Max Individual	$9,700
OOP Max Family	$19,400
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$40
Specialist Visit Copay	$80
Outpatient Diagnostic Labs / X-Ray	$20 / $75
Outpatient Complex Imaging	50% after deductible
Physical / Occupational Therapy	$40
Inpatient Hospital	50% after deductible
Outpatient Surgery	Facility: 50% after deductible / Freestanding: $300 after deductible / Physician: 50% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	50% after deductible
Ambulance	50% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	$225
Rx Retail	$25/$75/$90 after Rx deductible, does not apply to Tier 1
View Summary of Benefits (SBC)	

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

2026 Summary of Benefits

Anthem Blue Access Bronze EPO HSA 6300	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$6,300
Deductible Family	$12,600
OOP Max Individual	$8,450
OOP Max Family	$16,900
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$25 after deductible
Specialist Visit Copay	$75 after deductible
Outpatient Diagnostic Labs / X-Ray	50% after deductible
Outpatient Complex Imaging	50% after deductible
Physical / Occupational Therapy	50% after deductible
Inpatient Hospital	50% after deductible
Outpatient Surgery	50% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100 after deductible
ER Copay	50% after deductible
Ambulance	50% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	50% after deductible
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Anthem Connection Bronze EPO HSA 6300	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$6,300
Deductible Family	$12,600
OOP Max Individual	$8,450
OOP Max Family	$16,900
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$25 after deductible
Specialist Visit Copay	$75 after deductible
Outpatient Diagnostic Labs / X-Ray	50% after deductible
Outpatient Complex Imaging	50% after deductible
Physical / Occupational Therapy	50% after deductible
Inpatient Hospital	50% after deductible
Outpatient Surgery	50% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100 after deductible
ER Copay	50% after deductible
Ambulance	50% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: $0
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	50% after deductible
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

2026 Summary of Benefits

EmblemHealth Select Care Platinum Premier		
Deductibles/Out-of-Pocket Max	**In-Network**	**Out-of-Network**
Deductible Individual	$260	$4,000
Deductible Family	$520	$8,000
OOP Max Individual	$2,800	$10,000
OOP Max Family	$5,600	$20,000
Coinsurance	20%	50%
Cost Sharing	**In-Network**	**Out-of-Network**
PCP Visit Copay	$0 first 3 visits, then $10	50% coinsurance after deductible
Specialist Visit Copay	$35	50% coinsurance after deductible
Outpatient Diagnostic Labs / X-Ray	$125 after deductible	50% coinsurance after deductible
Outpatient Complex Imaging	$150 after deductible (pre-approval required)	50% coinsurance after deductible
Physical / Occupational Therapy	PCP: $10 after deductible, 60 visits max, Specialist: $35 after deductible, 60 visits max	50% coinsurance after deductible
Inpatient Hospital	Facility: 20% after deductible / Physician: $250 after deductible (pre-approval required)	50% coinsurance after deductible
Outpatient Surgery	Facility: $250 after deductible / Physician: $250 after deductible (pre-approval required)	50% coinsurance after deductible
Durable Medical Equipment	10% after deductible (pre-approval required)	Not Covered
Emergency/Urgent Care	**In-Network**	**Out-of-Network**
Urgent Care Copay	$100 after deductible	50% coinsurance after deductible
ER Copay	30% after deductible, waived if admitted	30% after deductible, waived if admitted
Ambulance	$250 after deductible	$250 after deductible
Pediatric Dental & Vision	**In-Network**	**Out-of-Network**
Pediatric Dental	Preventive services: $10	Not Covered
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: 10%	Not Covered
Precription Drugs	**In-Network**	**Out-of-Network**
Rx Deductible	In Network: $100 individual/$200 family	Not Covered
Rx Retail	$5/$30/$75 after Rx deductible, does not apply to Tier 1	Not Covered
View Summary of Benefits and Coverage (SBC)		

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

2026 Summary of Benefits

EmblemHealth Select Care Gold Premier		
Deductibles/Out-of-Pocket Max	**In-Network**	**Out-of-Network**
Deductible Individual	$500	$6,000
Deductible Family	$1,000	$12,000
OOP Max Individual	$8,650	$12,000
OOP Max Family	$17,300	$24,000
Coinsurance	30%	50%
Cost Sharing	**In-Network**	**Out-of-Network**
PCP Visit Copay	$0 first 3 visits, then $25 / 50% coinsurance after deductible	50% coinsurance after deductible
Specialist Visit Copay	$50 / 50% coinsurance after deductible	50% coinsurance after deductible
Outpatient Diagnostic Labs / X-Ray	$150 after deductible	50% coinsurance after deductible
Outpatient Complex Imaging	$175 after deductible (pre-approval required)	50% coinsurance after deductible
Physical / Occupational Therapy	PCP: $25 after deductible, 60 visits max, Specialist: $50 after deductible, 60 visits max	50% coinsurance after deductible
Inpatient Hospital	Facility: 30% after deductible / Physician: $350 after deductible (pre-approval required)	50% coinsurance after deductible
Outpatient Surgery	Facility: $350 after deductible / Physician: $350 after deductible (pre-approval required)	50% coinsurance after deductible
Durable Medical Equipment	20% after deductible (pre-approval required)	Not Covered
Emergency/Urgent Care	**In-Network**	**Out-of-Network**
Urgent Care Copay	$100 after deductible	50% coinsurance after deductible
ER Copay	40% after deductible, waived if admitted	40% after deductible, waived if admitted
Ambulance	$350 after deductible	$350 after deductible
Pediatric Dental & Vision	**In-Network**	**Out-of-Network**
Pediatric Dental	Preventive services: $25	Not covered
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: 20%	Not covered
Precription Drugs	**In-Network**	**Out-of-Network**
Rx Deductible	In Network: $150 individual/$300 family	Not covered
Rx Retail	$7/$40/$85 after Rx deductible, does not apply to Tier 1	Not covered
View Summary of Benefits and Coverage (SBC)		

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

2026 Summary of Benefits

EmblemHealth Select Care Silver Premier		
Deductibles/Out-of-Pocket Max	**In-Network**	**Out-of-Network**
Deductible Individual	$6,200	$8,000
Deductible Family	$12,400	$16,000
OOP Max Individual	$10,000	$18,000
OOP Max Family	$20,000	$36,000
Coinsurance	40%	50%
Cost Sharing	**In-Network**	**Out-of-Network**
PCP Visit Copay	$0 first visit, then $35	50% coinsurance after deductible
Specialist Visit Copay	$75	50% coinsurance after deductible
Outpatient Diagnostic Labs / X-Ray	$200 after deductible	50% coinsurance after deductible
Outpatient Complex Imaging	$200 after deductible (pre-approval required)	50% coinsurance after deductible
Physical / Occupational Therapy	PCP: $35 after deductible, 60 visits max, Specialist: $75 after deductible, 60 visits max	Not covered
Inpatient Hospital	Facility: 40% after deductible / Physician: $450 after deductible (pre-approval required)	50% coinsurance after deductible
Outpatient Surgery	Facility: $450 after deductible / Physician: $450 after deductible (pre-approval required)	50% coinsurance after deductible
Durable Medical Equipment	30% after deductible (pre-approval required)	Not covered
Emergency/Urgent Care	**In-Network**	**Out-of-Network**
Urgent Care Copay	$100 after deductible	50% coinsurance after deductible
ER Copay	50% after deductible, waived if admitted	50% after deductible, waived if admitted
Ambulance	$450 after deductible	$450 after deductible
Pediatric Dental & Vision	**In-Network**	**Out-of-Network**
Pediatric Dental	Preventive services: $35	Not covered
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: 30%	Not covered
Precription Drugs	**In-Network**	**Out-of-Network**
Rx Deductible	In Network: $250 individual/$500 family	Not covered
Rx Retail	$20/$50/$120 after Rx deductible, does not apply to Tier 1	Not covered
View Summary of Benefits and Coverage (SBC)		

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

2026 Summary of Benefits

EmblemHealth Select Care Silver HSA	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$3,500
Deductible Family	$7,000
OOP Max Individual	$8,000
OOP Max Family	$16,000
Coinsurance	40%
Cost Sharing	
PCP Visit Copay	$30 after deductible
Specialist Visit Copay	$50 after deductible
Outpatient Diagnostic Labs / X-Ray	$150 after deductible
Outpatient Complex Imaging	$200 after deductible (pre-approval required)
Physical / Occupational Therapy	PCP: $30 after deductible, 60 visits max, Specialist: $50 after deductible, 60 visits max
Inpatient Hospital	Facility: 40% after deductible / Physician: $450 after deductible (pre-approval required)
Outpatient Surgery	Facility: $450 after deductible / Physician: $450 after deductible (pre-approval required)
Durable Medical Equipment	30% after deductible (pre-approval required)
Emergency/Urgent Care	
Urgent Care Copay	$100 after deductible
ER Copay	50% after deductible, waived if admitted
Ambulance	$450 after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $30 after deductible
Pediatric Vision	1 exam/12 months: $0 after deductible, 1 pair/12 months: 30% after deductible
Precription Drugs	
Rx Deductible	In Network: Integrated
Rx Retail	$15/$45/$100 after deductible
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

EmblemHealth Select Care Bronze HSA	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$8,000
Deductible Family	$16,000
OOP Max Individual	$8,500
OOP Max Family	$17,000
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	50% after deductible
Specialist Visit Copay	50% after deductible
Outpatient Diagnostic Labs / X-Ray	50% after deductible
Outpatient Complex Imaging	50% after deductible (pre-approval required)
Physical / Occupational Therapy	50% after deductible, 60 visits max
Inpatient Hospital	50% after deductible (pre-approval required)
Outpatient Surgery	Facility: 50% after deductible / Physician: 50% after deductible (pre-approval required)
Durable Medical Equipment	50% after deductible (pre-approval required)
Emergency/Urgent Care	
Urgent Care Copay	50% after deductible
ER Copay	50% after deductible, waived if admitted
Ambulance	50% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: 50% after deductible
Pediatric Vision	1 exam/12 months: $0 after deductible, 1 pair/12 months: 50% after deductible
Precription Drugs	
Rx Deductible	In Network: Integrated
Rx Retail	$35/$65/$115 after deductible
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

EmblemHealth Select Care Bronze Premier	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$8,400
Deductible Family	$16,800
OOP Max Individual	$10,000
OOP Max Family	$20,000
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$0 first visit, then 50% after deductible
Specialist Visit Copay	50% after deductible
Outpatient Diagnostic Labs / X-Ray	50% after deductible
Outpatient Complex Imaging	50% after deductible (pre-approval required)
Physical / Occupational Therapy	50% after deductible, 60 visits max
Inpatient Hospital	50% after deductible (pre-approval required)
Outpatient Surgery	Facility: 50% after deductible / Physician: 50% after deductible (pre-approval required)
Durable Medical Equipment	50% after deductible (pre-approval required)
Emergency/Urgent Care	
Urgent Care Copay	50% after deductible
ER Copay	50% after deductible, waived if admitted
Ambulance	50% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $40
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	In Network: Integrated
Rx Retail	$50/50%/50% after deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

2026 Summary of Benefits

Oxford Freedom Platinum EPO 5/15 ZD	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$3,750
OOP Max Family	$7,500
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$5
Specialist Visit Copay	$15
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: $60 / Hospital: $60 / Office: $15 / $90
Outpatient Complex Imaging	$100
Physical / Occupational Therapy	$15, 60 visits max
Inpatient Hospital	Facility: $200 / Physician: $0
Outpatient Surgery	Facility: $100 / Physician: $0
Durable Medical Equipment	$0
Emergency/Urgent Care	
Urgent Care Copay	$50
ER Copay	$250
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $5, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$100 individual
Rx Retail	$5/$35/$70 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Freedom Platinum EPO 20/40 ZD	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$3,250
OOP Max Family	$6,500
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$20
Specialist Visit Copay	$40
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: $60 / Hospital: $60 / Office: $40 / $90
Outpatient Complex Imaging	$100
Physical / Occupational Therapy	$40, 60 visits max
Inpatient Hospital	Facility: $400 / Physician: $0
Outpatient Surgery	Facility: $300 / Physician: $0
Durable Medical Equipment	$0
Emergency/Urgent Care	
Urgent Care Copay	$50
ER Copay	$250
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $20, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$100 individual
Rx Retail	$5/$35/$70 after Rx deductible, does not apply to Generic
Rx Specialty	$15/$65/$95 after Rx deductible, does not apply to Generic
Rx Mail Order	$12.50/$87.50/$175 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Freedom Platinum EPO 10/25	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$250
Deductible Family	$500
OOP Max Individual	$2,750
OOP Max Family	$5,500
Coinsurance	10%
Cost Sharing	
PCP Visit Copay	$10
Specialist Visit Copay	$25
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: 50% after deductible / Hospital: 50% after deductible / Office: $25 / 10% after deductible
Outpatient Complex Imaging	10% after deductible
Physical / Occupational Therapy	$25, 60 visits max
Inpatient Hospital	10% after deductible
Outpatient Surgery	10% after deductible
Durable Medical Equipment	10% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$50
ER Copay	50% after deductible
Ambulance	
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $10, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$100 individual
Rx Retail	$5/$35/$70 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Freedom Gold EPO 25/50 ZD	
Deductibles/Out-of-Pocket Max	
Deductible Individual (IN / OON)	$0
Deductible Family (IN / OON)	$0 / N/A
OOP Max Individual (IN / OON)	$7,300 / N/A
OOP Max Family (IN / OON)	$14,600 / N/A
Coinsurance (IN / OON)	0% / N/A
Cost Sharing	
PCP Visit Copay	$25
Specialist Visit Copay	$50
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: $60 / Hospital: $60 / Office: $50 / $50
Outpatient Complex Imaging	$150
Physical / Occupational Therapy	$50, 60 visits max
Inpatient Hospital	Facility: $500 / Physician: $125
Outpatient Surgery	Facility: $250 / Physician: $125
Durable Medical Equipment	$0
Emergency/Urgent Care	
Urgent Care Copay	$75
ER Copay	$750
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $25, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$150 individual
Rx Retail	$10/$65/$95 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Freedom Gold EPO 15/35	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,750
Deductible Family	$3,500
OOP Max Individual	$8,000
OOP Max Family	$16,000
Coinsurance	10%
Cost Sharing	
PCP Visit Copay	$15
Specialist Visit Copay	$35
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: 50% after deductible / Hospital: 50% after deductible / Office: $35 / $80 after deductible
Outpatient Complex Imaging	$150 after deductible
Physical / Occupational Therapy	$35, 60 visits max
Inpatient Hospital	10% after deductible
Outpatient Surgery	Facility: $150 after deductible / Physician: 10% after deductible
Durable Medical Equipment	10% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$75
ER Copay	$500
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $15, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$150 individual
Rx Retail	$10/$40/$80 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Freedom Gold EPO 30/60	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$2,250
Deductible Family	$4,500
OOP Max Individual	$7,250
OOP Max Family	$14,500
Coinsurance	30%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$60
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: 50% after deductible / Hospital: 50% after deductible / Office: $60 / 30% after deductible
Outpatient Complex Imaging	30% after deductible
Physical / Occupational Therapy	$60, 60 visits max
Inpatient Hospital	30% after deductible
Outpatient Surgery	30% after deductible
Durable Medical Equipment	30% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$75
ER Copay	$500
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$150 individual
Rx Retail	$10/$40/$80 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Freedom Gold HSA 1700	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,700
Deductible Family	$3,400
OOP Max Individual	$5,750
OOP Max Family	$11,500
Coinsurance	10%
Cost Sharing	
PCP Visit Copay	10% after deductible
Specialist Visit Copay	10% after deductible
Outpatient Diagnostic Labs / X-Ray	10% after deductible
Outpatient Complex Imaging	10% after deductible
Physical / Occupational Therapy	10% after deductible, 60 visits max
Inpatient Hospital	10% after deductible
Outpatient Surgery	10% after deductible
Durable Medical Equipment	10% after deductible
Emergency/Urgent Care	
Urgent Care Copay	10% after deductible
ER Copay	50% after deductible
Ambulance	10% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: 50% after deductible
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	$10/$40/$80 after deductible
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Liberty Gold 25/50 ZD	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$7,300
OOP Max Family	$14,600
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$25
Specialist Visit Copay	$50
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: $60 / Hospital: $60 / Office: $50 / $50
Outpatient Complex Imaging	$150
Physical / Occupational Therapy	$50, 60 visits max
Inpatient Hospital	Facility: $500 / Physician: $125
Outpatient Surgery	Facility: $250 / Physician: $125
Durable Medical Equipment	$0
Emergency/Urgent Care	
Urgent Care Copay	$75
ER Copay	$750
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $25, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$200 individual
Rx Retail	$10/$50/$90 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Liberty Gold EPO 30/60 1250	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,250
Deductible Family	$2,500
OOP Max Individual	$7,000
OOP Max Family	$14,000
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$60
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: 50% after deductible / Hospital: 50% after deductible / Office: $60 / $35 after deductible
Outpatient Complex Imaging	$100 after deductible
Physical / Occupational Therapy	$60, 60 visits max
Inpatient Hospital	Facility: $500/day - $2,000 max/admission after deductible / Physician: $0 after deductible
Outpatient Surgery	Facility: $150 after deductible / Physician: $0 after deductible
Durable Medical Equipment	$0 after deductible
Emergency/Urgent Care	
Urgent Care Copay	$75
ER Copay	$500
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$200 individual
Rx Retail	$10/$50/$90 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Liberty Gold EPO 30/60 1800	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,800
Deductible Family	$3,600
OOP Max Individual	$7,500
OOP Max Family	$15,000
Coinsurance	30%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$60
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: 50% after deductible / Hospital: 50% after deductible / Office: $60 / 30% after deductible
Outpatient Complex Imaging	30% after deductible
Physical / Occupational Therapy	$60, 60 visits max
Inpatient Hospital	30% after deductible
Outpatient Surgery	30% after deductible
Durable Medical Equipment	30% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$75
ER Copay	$500
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$200 individual
Rx Retail	$10/$50/$90 after Rx deductible, does not apply to Generic
View Summary of Benefits and Soverage (SBC)	

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

2026 Summary of Benefits

Oxford Metro Gold EPO 25/40	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,250
Deductible Family	$2,500
OOP Max Individual	$6,700
OOP Max Family	$13,400
Coinsurance	20%
Cost Sharing	
PCP Visit Copay	$25
Specialist Visit Copay	$40
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: 50% after deductible / Hospital: 50% after deductible / Office: $40 / $50 after deductible
Outpatient Complex Imaging	$150 after deductible
Physical / Occupational Therapy	$40, 60 visits max
Inpatient Hospital	20% after deductible
Outpatient Surgery	Facility: $200 after deductible / Physician: 20% after deductible
Durable Medical Equipment	20% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$75
ER Copay	$500
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $25, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$150 individual
Rx Retail	$10/$65/$95 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Freedom Silver 50/100 ZD	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$9,300
OOP Max Family	$18,600
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$50
Specialist Visit Copay	$100
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: $60 / Hospital: $60 / Office: $100 / $200
Outpatient Complex Imaging	$300
Physical / Occupational Therapy	$100, 60 visits max
Inpatient Hospital	Facility: $1,500 / Physician: $125
Outpatient Surgery	Facility: $250 / Physician: $125
Durable Medical Equipment	$0
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	$1,500
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$200 individual
Rx Retail	$15/$65/$95 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Freedom Silver EPO 40/80	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$3,250
Deductible Family	$6,500
OOP Max Individual	$9,200
OOP Max Family	$18,400
Coinsurance	40%
Cost Sharing	
PCP Visit Copay	$40
Specialist Visit Copay	$80
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: 50% after deductible / Hospital: 50% after deductible / Office: $80 / 40% after deductible
Outpatient Complex Imaging	40% after deductible
Physical / Occupational Therapy	$80, 60 visits max
Inpatient Hospital	40% after deductible
Outpatient Surgery	40% after deductible
Durable Medical Equipment	40% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	50% after deductible
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$200 individual
Rx Retail	$10/$50/$90 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage	

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

2026 Summary of Benefits

Oxford Liberty Silver EPO 50/100 ZD	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$9,300
OOP Max Family	$18,600
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$50
Specialist Visit Copay	$100
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: $60 / Hospital: $60 / Office: $100 / $200
Outpatient Complex Imaging	$300
Physical / Occupational Therapy	$100, 60 visits max
Inpatient Hospital	Facility: $1,500 / Physician: $125
Outpatient Surgery	Facility: $250 / Physician: $125
Durable Medical Equipment	$0
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	$1,500
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$200 individual
Rx Retail	$15/$65/$95 after Rx deductible, does not apply to Generic
View summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Liberty Silver EPO 40/80	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$3,250
Deductible Family	$6,500
OOP Max Individual	$9,200
OOP Max Family	$18,400
Coinsurance	40%
Cost Sharing	
PCP Visit Copay	$40
Specialist Visit Copay	$80
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: 50% after deductible / Hospital: 50% after deductible / Office: $80 / 40% after deductible
Outpatient Complex Imaging	40% after deductible
Physical / Occupational Therapy	$80, 60 visits max
Inpatient Hospital	40% after deductible
Outpatient Surgery	40% after deductible
Durable Medical Equipment	40% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	50% after deductible
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$200 individual
Rx Retail	$10/$50/$90 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Liberty Silver EPO 30/60	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$4,500
Deductible Family	$9,000
OOP Max Individual	$9,800
OOP Max Family	$19,600
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$60
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: 50% after deductible / Hospital: 50% after deductible / Office: $60 / 50% after deductible
Outpatient Complex Imaging	50% after deductible
Physical / Occupational Therapy	$60, 60 visits max
Inpatient Hospital	50% after deductible
Outpatient Surgery	50% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	50% after deductible
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$200 individual
Rx Retail	$10/$50/$90 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage	

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

2026 Summary of Benefits

Oxford Liberty Silver 4000	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$4,000
Deductible Family	$8,000
OOP Max Individual	$8,000
OOP Max Family	$16,000
Coinsurance	20%
Cost Sharing	
PCP Visit Copay	20% after deductible
Specialist Visit Copay	20% after deductible
Outpatient Diagnostic Labs / X-Ray	20% after deductible
Outpatient Complex Imaging	20% after deductible
Physical / Occupational Therapy	20% after deductible, 60 visits max
Inpatient Hospital	20% after deductible
Outpatient Surgery	20% after deductible
Durable Medical Equipment	20% after deductible
Emergency/Urgent Care	
Urgent Care Copay	20% after deductible
ER Copay	50% after deductible
Ambulance	20% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: 50% after deductible
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	$10/$50/$90 after deductible
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Metro Silver EPO 50/100 ZD	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$9,300
OOP Max Family	$18,600
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$50
Specialist Visit Copay	$100
Telemedicine Copay	$0
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: $60 / Hospital: $60 / Office: $100 / $200
Outpatient Complex Imaging	$300
Physical / Occupational Therapy	$100, 60 visits max
Inpatient Hospital	Facility: $1,500 / Physician: $125
Outpatient Surgery	Facility: $250 / Physician: $125
Durable Medical Equipment	$0
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	$1,500
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$200 individual
Rx Retail	$15/$65/$95 after Rx deductible, does not apply to Generic
Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

Oxford Metro Silver 30/80	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$3,750
Deductible Family	$7,500
OOP Max Individual	$9,200
OOP Max Family	$18,400
Coinsurance	40%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$80
Outpatient Diagnostic Labs / X-Ray	Designated Network: $0, In Network: Freestanding: 50% after deductible / Hospital: 50% after deductible / Office: $80 / 40% after deductible
Outpatient Complex Imaging	40% after deductible
Physical / Occupational Therapy	$80, 60 visits max
Inpatient Hospital	40% after deductible
Outpatient Surgery	40% after deductible
Durable Medical Equipment	40% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100
ER Copay	50% after deductible
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$200 individual
Rx Retail	$10/$65/$95 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage	

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

2026 Summary of Benefits

Oxford Liberty Bronze HSA 5750	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$5,750
Deductible Family	$11,500
OOP Max Individual	$8,000
OOP Max Family	$16,000
Coinsurance	30%
Cost Sharing	
PCP Visit Copay	$25 after deductible
Specialist Visit Copay	$75 after deductible
Outpatient Diagnostic Labs / X-Ray	Freestanding: 30% after deductible / Hospital: 30% after deductible / Office: $75 after deductible / 30% after dedutictible
Outpatient Complex Imaging	30% after deductible
Physical / Occupational Therapy	$75 after deductible, 60 visits max
Inpatient Hospital	30% after deductible
Outpatient Surgery	30% after deductible
Durable Medical Equipment	30% after deductible
Emergency/Urgent Care	
Urgent Care Copay	30% after deductible
ER Copay	50% after deductible
Ambulance	30% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: 50% after deductible
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	30% after deductible
Summary of Benefits and Coverage	

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

2026 Summary of Benefits

Oxford Metro Bronze HSA 6500	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$6,500
Deductible Family	$13,000
OOP Max Individual	$8,000
OOP Max Family	$16,000
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$40 after deductible
Specialist Visit Copay	$75 after deductible
Outpatient Diagnostic Labs / X-Ray	Freestanding: $15 after deductible / Hospital: $15 after deductible / Office: $75 after deductible / 50% after deductible
Outpatient Complex Imaging	50% after deductible
Physical / Occupational Therapy	$75 after deductible, 60 visits max
Inpatient Hospital	50% after deductible
Outpatient Surgery	Facility: $500 after deductible / Physician: 50% after deductible
Durable Medical Equipment	50% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$100 after deductible
ER Copay	$500 after deductible
Ambulance	50% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: 50% after deductible
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	$10/$40/$80 after deductible
View Summary of Benefits and Coverage	

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

2026 Summary of Benefits

2026 Summary of Benefits

UnitedHealthcare Choice+ Platinum POS 15/25 EP-3F		
Deductibles/Out-of-Pocket Max	**In-Network**	**Out-of-Network**
Deductible Individual	$0	$5,000
Deductible Family	$0	$10,000
OOP Max Individual	$5,500	$10,000
OOP Max Family	$11,000	$20,000
Coinsurance	0%	20%
Cost Sharing	**In-Network**	**Out-of-Network**
PCP Visit Copay	$15	20% coinsurance
Specialist Visit Copay	$25	20% coinsurance
Outpatient Diagnostic Labs / X-Ray	$15 / $25	Lab not covered / x-ray 20% coinsurance
Outpatient Complex Imaging	$100	20% coinsurance
Physical / Occupational Therapy	$15, 60 visits max	20% coinsurance
Inpatient Hospital	Facility: $500 / Physician: $0	20% coinsurance
Outpatient Surgery	Facility: $300 / Physician: $0	20% coinsurance
Durable Medical Equipment	$0	Not covered
Emergency/Urgent Care	**In-Network**	**Out-of-Network**
Urgent Care Copay	$30	20% coinsurance
ER Copay	$300	$300
Ambulance	$0	$0
Pediatric Dental & Vision	**In-Network**	**Out-of-Network**
Pediatric Dental	Preventive services: $0	50% coinsurance
Pediatric Vision	1 exam/12 months: $15, 1 pair/12 months: 50%	50% coinsurance
Precription Drugs	**In-Network**	**Out-of-Network**
Rx Deductible	None	None
Rx Retail	$5/$25/$50	$5/$25/$50
View Summary of Benefits and coverage (SBC)		

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

2026 Summary of Benefits

UnitedHealthcare Select Platinum POS 15/25 EP 3U		
Deductibles/Out-of-Pocket Max	**In-Network**	**Out-of-Network**
Deductible Individual	$0	$5,000
Deductible Family	$0	$10,000
OOP Max Individual	$5,500	$10,000
OOP Max Family	$11,000	$20,000
Coinsurance	0%	20%
Cost Sharing	**In-Network**	**Out-of-Network**
PCP Visit Copay	$15	20% coinsurance
Specialist Visit Copay	$25	20% coinsurance
Outpatient Diagnostic Labs / X-Ray	$15 / $25	Lab not covered / x-ray 20% coinsurance
Outpatient Complex Imaging	$100	20% coinsurance
Physical / Occupational Therapy	$15, 60 visits max	20% coinsurance
Inpatient Hospital	Facility: $500 / Physician: $0	20% coinsurance
Outpatient Surgery	Facility: $300 / Physician: $0	20% coinsurance
Durable Medical Equipment	$0	Not covered
Emergency/Urgent Care	**In-Network**	**Out-of-Network**
Urgent Care Copay	$30	20% coinsurance
ER Copay	$300	$300
Ambulance	$0	$0
Pediatric Dental & Vision	**In-Network**	**Out-of-Network**
Pediatric Dental	Preventive services: $0	50% coinsurance
Pediatric Vision	1 exam/12 months: $15, 1 pair/12 months: 50%	50% coinsurance
Precription Drugs	**In-Network**	**Out-of-Network**
Rx Deductible	None	None
Rx Retail	$5/$25/$50	$5/$25/$50
View Summary of Benefits and Coverage (SBC)		

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

2026 Summary of Benefits

UnitedHealthcare Select Platinum EPO 15/25 EP-3H	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$5,500
OOP Max Family	$11,000
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$15
Specialist Visit Copay	$25
Outpatient Diagnostic Labs / X-Ray	$15 / $25
Outpatient Complex Imaging	$100
Physical / Occupational Therapy	$15, 60 visits max
Inpatient Hospital	Facility: $500 / Physician: $0
Outpatient Surgery	Facility: $300 / Physician: $0
Durable Medical Equipment	$0
Emergency/Urgent Care	
Urgent Care Copay	$30
ER Copay	$300
Ambulance	No charge
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $15, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	None
Rx Retail	$5/$25/$50
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Select Platinum EPO 15/25 EP-3N	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$5,500
OOP Max Family	$11,000
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$15
Specialist Visit Copay	$25
Telemedicine Copay	$0
Outpatient Diagnostic Labs / X-Ray	$40
Outpatient Complex Imaging	$100
Physical / Occupational Therapy	$15, 60 visits max
Inpatient Hospital	Facility: $500 / Physician: $0
Outpatient Surgery	Facility: $300 / Physician: $0
Durable Medical Equipment	$0
Emergency/Urgent Care	
Urgent Care Copay	$30
ER Copay	$300
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $15, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	None
Rx Retail	$5/$25/$50
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Select Platinum EPO 10/25 EP-39	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$7,000
OOP Max Family	$14,000
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$10
Specialist Visit Copay	$25
Outpatient Diagnostic Labs / X-Ray	$0 / $100
Outpatient Complex Imaging	$200
Physical / Occupational Therapy	$10, 60 visits max
Inpatient Hospital	Facility: $1,000 / Physician: $0
Outpatient Surgery	Facility: $250 / Physician: $0
Durable Medical Equipment	$0
Emergency/Urgent Care	
Urgent Care Copay	$50
ER Copay	$200
Ambulance	No charge
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $10, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$50 individual/$150 family
Rx Retail	$5/$30/$60 after Rx deductible, does not apply to Tier 1
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Platinum EPO 10/40(80) EP-4D	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$3,700
OOP Max Family	$7,400
Coinsurance	20%
Cost Sharing	
PCP Visit Copay	$10
Specialist Visit Copay	Designated Network: $40, In Network: $80
Outpatient Diagnostic Labs / X-Ray	$40
Outpatient Complex Imaging	$140
Physical / Occupational Therapy	$10, 60 visits max
Inpatient Hospital	20% coinsurance
Outpatient Surgery	20% coinsurance
Durable Medical Equipment	20% coinsurance
Emergency/Urgent Care	
Urgent Care Copay	$25
ER Copay	20% coinsurance
Ambulance	20% coinsurance
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $10, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	None
Rx Retail	$5/$40/$80
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Gold POS 40 60 1100 EP 3E		
	In-Network	**Out-of-Network**
Deductible Individual (IN / OON)	$1,000	$5,000
Deductible Family (IN / OON)	$2,200	$10,000
OOP Max Individual (IN / OON)	$8,500	$10,000
OOP Max Family (IN / OON)	$17,000	$20,000
Coinsurance (IN / OON)	20%	40%
Cost Sharing	**In-Network**	**Out-of-Network**
PCP Visit Copay	$40	40% coinsurance
Specialist Visit Copay	$60	40% coinsurance
Outpatient Diagnostic Labs / X-Ray	$40 / $60	Lab not covered / 40% coinsurance
Outpatient Complex Imaging	$100	40% coinsurance
Physical / Occupational Therapy	$40, 60 visits max	40% coinsurance
Inpatient Hospital	20% coinsurance	40% coinsurance
Outpatient Surgery	20% coinsurance	40% coinsurance
Durable Medical Equipment	20% coinsurance	Not covered
Emergency/Urgent Care	**In-Network**	**Out-of-Network**
Urgent Care Copay	$60	40% coinsurance
ER Copay	$250	$250
Ambulance	20% coinsurance	20% coinsurance
Pediatric Dental & Vision	**In-Network**	**Out-of-Network**
Pediatric Dental	Preventive services: $0 after deductible	50% coinsurance
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%	50% coinsurance
Precription Drugs	**In-Network**	**Out-of-Network**
Rx Deductible	None	None
Rx Retail	$15/$50/50% - $800 max	$15/$50/50% - $800 max
View Summary of Benefits and Coverage (SBC)		

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

2026 Summary of Benefits

UnitedHealthcare Choice+ Gold POS 40/60 1700 EP-4B		
Benefits Summary	**In-Network**	**Out-of-Network**
Deductible Individual	$1,700	$5,000
Deductible Family	$3,400	$10,000
OOP Max Individual	$8,500	$10,000
OOP Max Family	$17,000	$20,000
Coinsurance	20%	40%
Cost Sharing	**In-Network**	**Out-of-Network**
PCP Visit Copay	$40	40% coinsurance
Specialist Visit Copay	$60	40% coinsurance
Outpatient Diagnostic Labs / X-Ray	$40 / $60	Lab not covered / 40% coinsurance
Outpatient Complex Imaging	$100	40% coinsurance
Physical / Occupational Therapy	$40, 60 visits max	40% coinsurance
Inpatient Hospital	20% after deductible	40% coinsurance
Outpatient Surgery	20% after deductible	40% coinsurance
Durable Medical Equipment	20% after deductible	Not covered
Emergency/Urgent Care	**In-Network**	**Out-of-Network**
Urgent Care Copay	$60	40% coinsurance
ER Copay	$250	$250
Ambulance	20% coinsurance	20% coinsurance
Pediatric Dental & Vision	**In-Network**	**Out-of-Network**
Pediatric Dental	Preventive services: $0 after deductible	50% coinsurance
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%	50% coinsurance
Precription Drugs	**In-Network**	**Out-of-Network**
Rx Deductible	None	None
Rx Retail	$15/$50/50% - $800 max	$15/$50/50% - $800 max
View Summary of Benefits and Coverage (SBC)		

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

2026 Summary of Benefits

UnitedHealthcare Select+ Gold POS 40/60 1100 EP-3W		
Deductibles/Out-of-Pocket Max	**In-Network**	**Out-of-Network**
Deductible Individual (IN / OON)	$1,100	$5,000
Deductible Family (IN / OON)	$2,200	$10,000
OOP Max Individual (IN / OON)	$8,500	$10,000
OOP Max Family (IN / OON)	$17,000	$20,000
Coinsurance (IN / OON)	20%	40%
Cost Sharing	**In-Network**	**Out-of-Network**
PCP Visit Copay	$40	40% coinsurance
Specialist Visit Copay	$60	40% coinsurance
Outpatient Diagnostic Labs / X-Ray	$40 / $60	Lab not covered / 40% coinsurance
Outpatient Complex Imaging	$100	40% coinsurance
Physical / Occupational Therapy	$40, 60 visits max	40% coinsurance
Inpatient Hospital	20% after deductible	40% coinsurance
Outpatient Surgery	20% after deductible	40% coinsurance
Durable Medical Equipment	20% after deductible	Not covered
Emergency/Urgent Care	**In-Network**	**Out-of-Network**
Urgent Care Copay	$60	40% coinsurance
ER Copay	$250 per visit, decutible does not apply	$250 per visit, decutible does not apply
Ambulance	20% coinsurance	20% coinsurance
Pediatric Dental & Vision	**In-Network**	**Out-of-Network**
Pediatric Dental	Preventive services: $0 after deductible	50% coinsurance
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%	50% coinsurance
Precription Drugs	**In-Network**	**Out-of-Network**
Rx Deductible	None	None
Rx Retail	$15/$50/50% - $800 max	$15/$50/50% - $800 max
View Summary of Benefits and Coverage (SBC)		

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

2026 Summary of Benefits

UnitedHealthcare Choice Gold EPO 30/65 EP-3L	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$450
Deductible Family	$900
OOP Max Individual	$9,900
OOP Max Family	$19,800
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$65
Outpatient Diagnostic Labs / X-Ray	$50 after deductible / $75 after deductible
Outpatient Complex Imaging	$175 after deductible
Physical / Occupational Therapy	$30, 60 visits max
Inpatient Hospital	Facility: $1,500 after deductible / Physician: $0 after deductible
Outpatient Surgery	Facility: $150 after deductible / Physician: $0 after deductible
Durable Medical Equipment	$0 after deductible
Emergency/Urgent Care	
Urgent Care Copay	$70
ER Copay	$400 after deductible
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	None
Rx Retail	$10/$50/$100
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Gold EPO 40/70 EP-3I	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$0
Deductible Family	$0
OOP Max Individual	$9,200
OOP Max Family	$18,400
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$40
Specialist Visit Copay	$70
Outpatient Diagnostic Labs / X-Ray	$70
Outpatient Complex Imaging	$100
Physical / Occupational Therapy	$40, 60 visits max
Inpatient Hospital	Facility: $1,500 / Physician: $0
Outpatient Surgery	Facility: $650 / Physician: $0
Durable Medical Equipment	$0
Emergency/Urgent Care	
Urgent Care Copay	$70
ER Copay	$650
Ambulance	$0
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	None
Rx Retail	$15/$100/50%
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Gold EPO 40/60 EP-3G	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,100
Deductible Family	$2,200
OOP Max Individual	$8,500
OOP Max Family	$17,000
Coinsurance	20%
Cost Sharing	
PCP Visit Copay	$40
Specialist Visit Copay	$60
Outpatient Diagnostic Labs / X-Ray	$40 / $60
Outpatient Complex Imaging	$100
Physical / Occupational Therapy	$40, 60 visits max
Inpatient Hospital	20% coinsurance
Outpatient Surgery	20% coinsurance
Durable Medical Equipment	20% coinsurance
Emergency/Urgent Care	
Urgent Care Copay	$60
ER Copay	$250
Ambulance	20% coinsurance
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	None
Rx Retail	$15/$50/50% - $800 max
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Gold EPO 15/30 EP-3A	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,700
Deductible Family	$3,500
OOP Max Individual	$8,600
OOP Max Family	$17,200
Coinsurance	20%
Cost Sharing	
PCP Visit Copay	$15
Specialist Visit Copay	$30
Outpatient Diagnostic Labs / X-Ray	$50 after deductible
Outpatient Complex Imaging	$150 after deductible
Physical / Occupational Therapy	$15, 60 visits max
Inpatient Hospital	20% after deductible
Outpatient Surgery	20% after deductible
Durable Medical Equipment	20% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$65
ER Copay	$400
Ambulance	20% coinsurance
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $15, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	None
Rx Retail	$10/$65/50% - $800 max
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Select Gold POS 15-30 EP3X	
Benefits Summary	
Deductible Individual	$1,750
Deductible Family	$3,500
OOP Max Individual	$8,600
OOP Max Family	$17,200
Coinsurance	20%
Cost Sharing	
PCP Visit Copay	$15
Specialist Visit Copay	$30
Outpatient Diagnostic Labs / X-Ray	$50 after deductible
Outpatient Complex Imaging	$150 after deductible
Physical / Occupational Therapy	$15, 60 visits max
Inpatient Hospital	20% after deductible
Outpatient Surgery	20% after deductible
Durable Medical Equipment	20% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$65
ER Copay	$400
Ambulance	20% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $15, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	In Network: None
Rx Retail	$10/$65/50% - $800 max
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Gold EPO 15/50(100) EP-4F	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$2,500
Deductible Family	$5,000
OOP Max Individual	$7,150
OOP Max Family	$14,300
Coinsurance	25%
Cost Sharing	
PCP Visit Copay	$15
Specialist Visit Copay	Designated Network: $50, In Network: $100
Outpatient Diagnostic Labs / X-Ray	25% after deductible
Outpatient Complex Imaging	25% after deductible
Physical / Occupational Therapy	$15, 60 visits max
Inpatient Hospital	25% after deductible
Outpatient Surgery	25% after deductible
Durable Medical Equipment	25% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$25
ER Copay	25% after deductible
Ambulance	25% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $15, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	None
Rx Retail	$10/$50/$100
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Gold EPO HSA 1800/100% EP-3Q	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,800
Deductible Family	$3,600
OOP Max Individual	$5,500
OOP Max Family	$8,900
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$0 after deductible
Specialist Visit Copay	$0 after deductible
Outpatient Diagnostic Labs / X-Ray	$40 after deductible / $100 after deductible
Outpatient Complex Imaging	$200 after deductible
Physical / Occupational Therapy	$0 after deductible, 60 visits max
Inpatient Hospital	Facility: $1,200 after deductible / Physician: $0 after deductible
Outpatient Surgery	Facility: $800 after deductible / Physician: $0 after deductible
Durable Medical Equipment	$0 after deductible
Emergency/Urgent Care	
Urgent Care Copay	$0 after deductible
ER Copay	$500 after deductible
Ambulance	0% coinsurance
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: 50% after deductible
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	$5/$45/$90 after deductible
View summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Gold EPO HSA 1800/80% EP-3C	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$1,800
Deductible Family	$3,600
OOP Max Individual	$5,000
OOP Max Family	$10,000
Coinsurance	20
Cost Sharing	
PCP Visit Copay	20% after deductible
Specialist Visit Copay	20% after deductible
Outpatient Diagnostic Labs / X-Ray	20% after deductible
Outpatient Complex Imaging	20% after deductible
Physical / Occupational Therapy	20% after deductible, 60 visits max
Inpatient Hospital	20% after deductible
Outpatient Surgery	20% after deductible
Durable Medical Equipment	20% after deductible
Emergency/Urgent Care	
Urgent Care Copay	20% after deductible
ER Copay	20% after deductible
Ambulance	20% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: 20%, 1 pair/12 months: 50% after deductible
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	$5/$45/$90 after deductible
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Gold EPO HSA 2500/100% EP-3R	
Deductibles/Out-of-Pocket Max	
Deductible Individual	$2,500
Deductible Family	$5,000
OOP Max Individual	$5,500
OOP Max Family	$8,900
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$0 after deductible
Specialist Visit Copay	$0 after deductible
Outpatient Diagnostic Labs / X-Ray	$40 after deductible / $100 after deductible
Outpatient Complex Imaging	$200 after deductible
Physical / Occupational Therapy	$0 after deductible, 60 visits max
Inpatient Hospital	Facility: $1,200 after deductible / Physician: $0 after deductible
Outpatient Surgery	Facility: $800 after deductible / Physician: $0 after deductible
Durable Medical Equipment	$0 after deductible
Emergency/Urgent Care	
Urgent Care Copay	$0 after deductible
ER Copay	$500 after deductible
Ambulance	$0 after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: 50% after deductible
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	$5/$45/$90 after deductible
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice+ Silver POS HSA 3000/100% EP-3J		
Benefits Summary	**In-Network**	**Out-of-Network**
Deductible Individual	$3,000	$5,000
Deductible Family	$6,000	$10,000
OOP Max Individual	$8,300	$10,000
OOP Max Family	$16,600	$20,000
Coinsurance	0%	50%
Cost Sharing	**In-Network**	**Out-of-Network**
PCP Visit Copay	$30 after deductible	50% coinsurance
Specialist Visit Copay	$50 after deductible	50% coinsurance
Outpatient Diagnostic Labs / X-Ray	$50 after deductible	50% coinsurance
Outpatient Complex Imaging	$100 after deductible	50% coinsurance
Physical / Occupational Therapy	$30 after deductible, 60 visits max	50% coinsurance
Inpatient Hospital	Facility: $1,500 after deductible / Physician: 0% coinsurance	50% coinsurance
Outpatient Surgery	Facility: $250 / Physician: 0% coinsurance	50% coinsurance
Durable Medical Equipment	0% coinsurance	Not covered
Emergency/Urgent Care	**In-Network**	**Out-of-Network**
Urgent Care Copay	$75 after deductible	50% coinsurance
ER Copay	$500 after deductible	$500 after deductible
Ambulance	0% coinsurance	0% coinsurance
Pediatric Dental & Vision	**In-Network**	**Out-of-Network**
Pediatric Dental	Preventive services: $0 after deductible	50% coinsurance
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50% after deductible	50% coinsurance
Precription Drugs		**Out-of-Network**
Rx Deductible	Integrated	Integrated
Rx Retail	$10/$40/$60 after deductible	$10/$40/$60 after deductible
View Summary of Benefits and Coverage (SBC)		

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

2026 Summary of Benefits

UnitedHealthcare Choice Silver EPO HSA 3000/100% EP-36	
Benefits Summary	
Deductible Individual	$3,000
Deductible Family	$6,000
OOP Max Individual	$8,300
OOP Max Family	$16,600
Coinsurance	0%
Cost Sharing	
PCP Visit Copay	$30 after deductible
Specialist Visit Copay	$50 after deductible
Outpatient Diagnostic Labs / X-Ray	$50 after deductible
Outpatient Complex Imaging	$150 after deductible
Physical / Occupational Therapy	$30 after deductible, 60 visits max
Inpatient Hospital	Facility: $1,500 after deductible / Physician: $0 after deductible
Outpatient Surgery	Facility: $250 after deductible / Physician: $0 after deductible
Durable Medical Equipment	$0 after deductible
Emergency/Urgent Care	
Urgent Care Copay	$75 after deductible
ER Copay	$500 after deductible
Ambulance	0% coinsurance
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50% after deductible
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	$10/$40/$60 after deductible
View summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Silver EPO HSA 3400/80% EP-3D	
Benefits Summary	
Deductible Individual	$3,400
Deductible Family	$6,800
OOP Max Individual	$8,300
OOP Max Family	$16,600
Coinsurance	20%
Cost Sharing	
PCP Visit Copay	20% after deductible
Specialist Visit Copay	20% after deductible
Outpatient Diagnostic Labs / X-Ray	20% after deductible
Outpatient Complex Imaging	20% after deductible
Physical / Occupational Therapy	20% after deductible, 60 visits max
Inpatient Hospital	20% after deductible
Outpatient Surgery	20% after deductible
Durable Medical Equipment	20% after deductible
Emergency/Urgent Care	
Urgent Care Copay	20% after deductible
ER Copay	20% after deductible
Ambulance	20% after deductible
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: 20%, 1 pair/12 months: 50% after deductible
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	$15/$35/$75 after deductible
View summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Silver EPO 15/50(100) EP-4H	
Benefits Summary	
Deductible Individual	$7,000
Deductible Family	$14,000
OOP Max Individual	$9,700
OOP Max Family	$19,400
Coinsurance	25%
Cost Sharing	
PCP Visit Copay	$15
Specialist Visit Copay	Designated Network: $50, In Network: $100
Outpatient Diagnostic Labs / X-Ray	25% coinsurance
Outpatient Complex Imaging	25% coinsurance
Physical / Occupational Therapy	$15, 60 visits max
Inpatient Hospital	25% coinsurance
Outpatient Surgery	25% coinsurance
Durable Medical Equipment	25% coinsurance
Emergency/Urgent Care	
Urgent Care Copay	$25
ER Copay	25% coinsurance
Ambulance	25% coinsurance
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $15, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$100 individual
Rx Retail	$10/$50/$100 after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice Silver EPO 30/75 EP-3B	
Benefits Summary	
Deductible Individual	$4,250
Deductible Family	$8,500
OOP Max Individual	$9,100
OOP Max Family	$18,200
Coinsurance	50%
Cost Sharing	
PCP Visit Copay	$30
Specialist Visit Copay	$75
Outpatient Diagnostic Labs / X-Ray	50% coinsurance
Outpatient Complex Imaging	50% coinsurance
Physical / Occupational Therapy	$30, 60 visits max
Inpatient Hospital	50% coinsurance
Outpatient Surgery	50% coinsurance
Durable Medical Equipment	50% coinsurance
Emergency/Urgent Care	
Urgent Care Copay	$80
ER Copay	$900 after deductible
Ambulance	50% coinsurance
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0 after deductible
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	$100 individual/$300 family
Rx Retail	$15/$65/50% - $800 max after Rx deductible, does not apply to Generic
View Summary of Benefits and Coverage (SBC)	

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

2026 Summary of Benefits

UnitedHealthcare Choice+ Bronze POS HSA 7750/100% EP-29		
Benefits Summary	**In-Network**	**Out-of-Network**
Deductible Individual	$7,750	$10,000
Deductible Family	$15,500	$20,000
OOP Max Individual	$7,750	$20,000
OOP Max Family	$15,500	$40,000
Coinsurance	0%	50%
Cost Sharing	**In-Network**	**Out-of-Network**
PCP Visit Copay	$0 after deductible	50% coinsurance
Specialist Visit Copay	$0 after deductible	50% coinsurance
Outpatient Diagnostic Labs / X-Ray	$0 after deductible	Lab not covered / 50% coinsurance
Outpatient Complex Imaging	$0 after deductible	50% coinsurance
Physical / Occupational Therapy	$0 after deductible, 60 visits max	50% coinsurance
Inpatient Hospital	Facility: $0 after deductible / Physician: $0 after deductible	50% coinsurance
Outpatient Surgery	Facility: $0 after deductible / Physician: $0 after deductible	50% coinsurance
Durable Medical Equipment	$0 after deductible	Not covered
Emergency/Urgent Care	**In-Network**	**Out-of-Network**
Urgent Care Copay	$0 after deductible	50% coinsurance
ER Copay	$0 after deductible	0% coinsurance
Ambulance	$0 after deductible	0% coinsurance
Pediatric Dental & Vision	**In-Network**	**Out-of-Network**
Pediatric Dental	Preventive services: $0 after deductible	50% coinsurance
Pediatric Vision	1 exam/12 months: $0, 1 pair/12 months: 50% after deductible	50% coinsurance
Precription Drugs		**Out-of-Network**
Rx Deductible	Integrated	Integrated
Rx Retail	$0 after deductible	$0 after deductible
View Summary of Benefits and Coverage (SBC)		

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

2026 Summary of Benefits

UnitedHealthcare Choice Bronze EPO 6150 EP-3M	
Benefits Summary	
Deductible Individual	$6,150
Deductible Family	$12,300
OOP Max Individual	$9,200
OOP Max Family	$18,400
Coinsurance	30%
Cost Sharing	
PCP Visit Copay	$35 after deductible
Specialist Visit Copay	$60 after deductible
Outpatient Diagnostic Labs / X-Ray	$35 after deductible
Outpatient Complex Imaging	$60 after deductible
Physical / Occupational Therapy	$35 after deductible, 60 visits max
Inpatient Hospital	30% after deductible
Outpatient Surgery	Facility: $300 after deductible / Physician: 30% after deductible
Durable Medical Equipment	30% after deductible
Emergency/Urgent Care	
Urgent Care Copay	$60 after deductible
ER Copay	$350 after deductible
Ambulance	30% coinsurance
Pediatric Dental & Vision	
Pediatric Dental	Preventive services: $0
Pediatric Vision	1 exam/12 months: $30, 1 pair/12 months: 50%
Precription Drugs	
Rx Deductible	Integrated
Rx Retail	$10/$40/$60 after deductible
View Summary of Benefits and Coverage (SBC)	

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