

	<b>Aetna Gold OAEPO 1000 90% ID: 14041846* (EPOc) (UCR=N/A)</b>	<b>EmblemHealth EH Gold Premier NG Prime* (HMOc) (UCR=N/A)</b>	<b>EmblemHealth EH Gold Choice NG Select Care* (HMOc) (UCR=N/A)</b>	<b>Empire Blue Access Gold Blue Access EPO 35/10%/5850* (EPOc) (UCR=N/A)</b>	<b>Empire EPO/PPO Gold EPO 25/0%/6000* (EPO) (UCR=N/A)</b>	<b>HealthFirst Gold 25/50/0 Pro EPO* (EPO) (UCR=N/A)</b>	<b>Oscar Circle Circle Gold \$0* (EPOc) (UCR=N/A)</b>	<b>Oscar Circle Plus Circle Plus Gold \$0* (EPOc) (UCR=N/A)</b>
<b>Prescription Drugs</b>								
Drug Card	15/65/50%/TCS/100 ded T2-4	10/30/70	20/45/75 IntDed T2-3	10/50/75	10/50/75	10/50/85	10/25/100	10/25/100
<b>In-Network</b>								
Ind/Fam Deductible	\$1,000/\$2,000 embedded	\$450/\$900	\$750/\$1,500	N/A	N/A	N/A	N/A	N/A
Ind/Fam OOP Limit	\$6,000/\$12,000 (incl ded)	\$4,000/\$8,000 (incl ded)	\$5,000/\$10,000 (incl ded)	\$5,850/\$11,700	\$6,000/\$12,000	\$7,000/\$14,000 (incl ded)	\$5,000/\$10,000	\$5,000/\$10,000
Co-Insurance	10%	0%	0%	10%	0%	0%	20%	20%
Primary Care	\$30 ded waived	No charge visits 1-3; \$30 ded waived visits 4+	No charge visits 1-3; \$30 ded waived visits 4+	\$35	\$25	\$25	\$25	\$25
Specialist	\$60 ded waived	\$50 ded waived	\$50 ded waived	\$50	\$50	\$50	\$50	\$50
Inpatient Hospital	10% after ded	\$1,000/admit after ded	\$2,000/admit after ded	\$500/day; 4 days/admit	\$400/day; 4 days max/admit	\$500/admit	\$500/day; 5 days/admit	\$500/day; 5 days/admit
<b>Out-Network</b>								
Ind/Fam Deductible								
Ind/Fam OOP Limit								
Co-Insurance								
Primary Care								
Specialist								
Inpatient Hospital								
<b>Single</b>	0 x \$1,008.74	0 x \$1,045.16	0 x \$889.66	0 x \$880.68	0 x \$958.99	0 x \$744.15	0 x \$734.02	0 x \$819.18
<b>EE with Spouse</b>	0 x \$2,017.49	0 x \$2,090.33	0 x \$1,779.33	0 x \$1,761.36	0 x \$1,917.98	0 x \$1,488.30	0 x \$1,468.05	0 x \$1,638.37
<b>EE with Child(ren)</b>	0 x \$1,714.86	0 x \$1,776.78	0 x \$1,512.43	0 x \$1,497.16	0 x \$1,630.28	0 x \$1,265.06	0 x \$1,247.84	0 x \$1,392.61
<b>Family</b>	0 x \$2,874.92	0 x \$2,978.72	0 x \$2,535.55	0 x \$2,509.94	0 x \$2,733.12	0 x \$2,120.83	0 x \$2,091.97	0 x \$2,334.67
<b>Monthly Cost</b>	0 \$0.00	0 \$0.00	0 \$0.00	0 \$0.00	0 \$0.00	0 \$0.00	0 \$0.00	0 \$0.00
<b>Annual Cost</b>	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

	Oxford Metro M Gold EPO 25/40 Non-Gated OHI CNT* (EPOc) (UCR=N/A)		Oxford Liberty L Gold EPO 30/60 Gated OHI CNT* (EPOc) (UCR=N/A)		Oxford Freedom F Gold EPO 15/35 Non-Gated OHI CNT* (EPOc) (UCR=N/A)	
Prescription Drugs						
Drug Card	10/65/90/100 ded T2-3		15/35/75/100 ded T2-3		15/35/75/100 ded T2-3	
In-Network						
Ind/Fam Deductible	\$1,250/\$2,500		\$1,000/\$2,000		\$1,000/\$2,000	
Ind/Fam OOP Limit	\$5,000/\$10,000 (incl ded)		\$4,500/\$9,000 (incl ded)		\$5,250/\$10,500 (incl ded)	
Co-Insurance	20%		0%		10%	
Primary Care	\$25 ded waived		\$30 ded waived		\$15 ded waived	
Specialist	\$40 ded waived		\$60 ded waived		\$35 ded waived	
Inpatient Hospital	20% after ded		\$500/day after ded; \$2,000 max/admit		10% after ded	
Out-Network						
Ind/Fam Deductible						
Ind/Fam OOP Limit						
Co-Insurance						
Primary Care						
Specialist						
Inpatient Hospital						
<b>Single</b>	<b>0 x</b>	<b>\$734.91</b>	<b>0 x</b>	<b>\$840.72</b>	<b>0 x</b>	<b>\$936.72</b>
<b>EE with Spouse</b>	<b>0 x</b>	<b>\$1,469.81</b>	<b>0 x</b>	<b>\$1,681.45</b>	<b>0 x</b>	<b>\$1,873.44</b>
<b>EE with Child(ren)</b>	<b>0 x</b>	<b>\$1,249.34</b>	<b>0 x</b>	<b>\$1,429.24</b>	<b>0 x</b>	<b>\$1,592.43</b>
<b>Family</b>	<b>0 x</b>	<b>\$2,094.48</b>	<b>0 x</b>	<b>\$2,396.07</b>	<b>0 x</b>	<b>\$2,669.65</b>
<b>Monthly Cost</b>	<b>0</b>	<b>\$0.00</b>	<b>0</b>	<b>\$0.00</b>	<b>0</b>	<b>\$0.00</b>
<b>Annual Cost</b>		<b>\$0.00</b>		<b>\$0.00</b>		<b>\$0.00</b>

Aetna  
Gold OAEP0 1000 90% ID: 14041846\* (EPOc) (UCR=N/A)

In-Network

Out-Network

**Prescription Drugs**

Drug Card 15/65/50%/TCS/100 ded T2-4

**Cost Share Information**

Individual/Family Deductible \$1,000/\$2,000 embedded  
Individual/Family OOP Limit \$6,000/\$12,000 (incl ded)  
Co-Insurance 10%  
Lifetime Maximum None

**Office Visits**

Primary Care \$30 ded waived  
Specialist \$60 ded waived  
Adult Preventive Care No charge; visit limits apply  
Child Preventive Care No charge; visit limits apply  
Maternity Prenatal/Postnatal Care Pre-No charge; Post-refer to carrier

Rehabilitation Services \$60 ded waived; visit limits apply

Chiropractic Care \$60 ded waived

**Inpatient Services**

Inpatient Hospital 10% after ded  
Inpatient Surgery Refer to Inpatient Hospital  
Maternity Delivery/Inpatient 10% after ded  
Mental Health Inpatient 10% after ded  
Substance Abuse Inpatient 10% after ded

**Outpatient Services**

Outpatient Facility Refer to Outpatient Surgery  
Outpatient Surgery 10% after ded  
Lab/X-Ray 10% after ded

Advanced Radiology 10% after ded  
Mental Health Outpatient \$60 ded waived  
Substance Abuse Outpatient \$60 ded waived

**Emergency Care**

Emergency Room \$750 (waived if admitted) ded waived  
Ambulance 10% after ded  
Urgent Care \$75 ded waived

**Recovery/Special Needs**

Home Health Care 25% ded waived; 40 visits/cal yr  
Habilitation services \$60 ded waived; visit limits apply

Skilled Nursing 10% after ded

Durable Medical Equipment 50% after ded  
Hospice Services 10% after ded

**Miscellaneous Services**

Pediatric Vision Exam 50% after ded; 1 exam/12 mo  
Pediatric Vision Hardware 50% after ded; 1 pair/12 mo  
Pediatric Dental Check-Up 0% after ded; 1 exam/6 mo

EmblemHealth EH Gold Premier NG Prime* (HMOc) (UCR=N/A)		
	In-Network	Out-Network
<b>Prescription Drugs</b>		
Drug Card	10/30/70	
<b>Cost Share Information</b>		
Individual/Family Deductible	\$450/\$900	
Individual/Family OOP Limit	\$4,000/\$8,000 (incl ded)	
Co-Insurance	0%	
Lifetime Maximum	None	
<b>Office Visits</b>		
Primary Care	No charge visits 1-3; \$30 ded waived visits 4+	
Specialist	\$50 ded waived	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	\$50 after ded; 90 visits/cond/plan yr comb PT/OT/ST	
Chiropractic Care	\$50 ded waived	
<b>Inpatient Services</b>		
Inpatient Hospital	\$1,000/admit after ded	
Inpatient Surgery	\$150 after ded	
Maternity Delivery/Inpatient	\$1,000/admit after ded	
Mental Health Inpatient	\$1,000/admit after ded	
Substance Abuse Inpatient	\$1,000/admit after ded	
<b>Outpatient Services</b>		
Outpatient Facility	\$150 after ded	
Outpatient Surgery	\$150 after ded	
Lab/X-Ray	Lab-PCP-\$30 ded waived; SP-\$50 ded waived; X-ray-PCP-\$30 after ded; SP-\$50 after ded	
Advanced Radiology	\$50 after ded	
Mental Health Outpatient	\$30 ded waived	
Substance Abuse Outpatient	\$30 ded waived	
<b>Emergency Care</b>		
Emergency Room	\$300 (waived if admitted) after ded	
Ambulance	\$150 after ded	
Urgent Care	\$75 ded waived	
<b>Recovery/Special Needs</b>		
Home Health Care	\$50 after ded; 40 visits/plan yr	
Habilitation services	\$50 after ded; 90 visits/cond/plan yr comb PT/OT/ST	
Skilled Nursing	\$1,000/admit after ded; 200 days/plan yr	
Durable Medical Equipment	20% after ded	
Hospice Services	\$1,000/admit after ded; 210 days/plan yr	
<b>Miscellaneous Services</b>		
Pediatric Vision Exam	No charge; 1 exam/12 mo	
Pediatric Vision Hardware	20% ded waived; 1 pair/12 mo	
Pediatric Dental Check-Up	No charge; 1 exam/6 mo	

EmblemHealth EH Gold Choice NG Select Care* (HMOc) (UCR=N/A)		
	In-Network	Out-Network
<b>Prescription Drugs</b>		
Drug Card	20/45/75 IntDed T2-3	
<b>Cost Share Information</b>		
Individual/Family Deductible	\$750/\$1,500	
Individual/Family OOP Limit	\$5,000/\$10,000 (incl ded)	
Co-Insurance	0%	
Lifetime Maximum	None	
<b>Office Visits</b>		
Primary Care	No charge visits 1-3; \$30 ded waived visits 4+	
Specialist	\$50 ded waived	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	\$50 after ded; 90 visits/cond/plan yr comb PT/OT/ST	
Chiropractic Care	\$50 ded waived	
<b>Inpatient Services</b>		
Inpatient Hospital	\$2,000/admit after ded	
Inpatient Surgery	\$150 after ded	
Maternity Delivery/Inpatient	\$2,000/admit after ded	
Mental Health Inpatient	\$2,000/admit after ded	
Substance Abuse Inpatient	\$2,000/admit after ded	
<b>Outpatient Services</b>		
Outpatient Facility	\$150 after ded	
Outpatient Surgery	\$150 after ded	
Lab/X-Ray	Lab-PCP-\$30 ded waived; SP-\$50 ded waived; X-ray-PCP-\$30 after ded; SP-\$50 after ded	
Advanced Radiology	\$50 after ded	
Mental Health Outpatient	\$30 ded waived	
Substance Abuse Outpatient	\$30 ded waived	
<b>Emergency Care</b>		
Emergency Room	\$300 (waived if admitted) after ded	
Ambulance	\$150 after ded	
Urgent Care	\$75 ded waived	
<b>Recovery/Special Needs</b>		
Home Health Care	\$50 after ded; 40 visits/plan yr	
Habilitation services	\$50 after ded; 90 visits/cond/plan yr comb PT/OT/ST	
Skilled Nursing	\$2,000/admit after ded; 200 days/plan yr	
Durable Medical Equipment	20% after ded	
Hospice Services	\$2,000/admit after ded; 210 days/plan yr	
<b>Miscellaneous Services</b>		
Pediatric Vision Exam	No charge; 1 exam/12 mo	
Pediatric Vision Hardware	20% ded waived; 1 pair/12 mo	
Pediatric Dental Check-Up	No charge; 1 exam/6 mo	

Empire Blue Access  
Gold Blue Access EPO 35/10%/5850\* (EPOc) (UCR=N/A)

In-Network

Out-Network

**Prescription Drugs**

Drug Card 10/50/75

**Cost Share Information**

Individual/Family Deductible N/A  
Individual/Family OOP Limit \$5,850/\$11,700  
Co-Insurance 10%  
Lifetime Maximum None

**Office Visits**

Primary Care \$35

Specialist \$50  
Adult Preventive Care No charge  
Child Preventive Care No charge  
Maternity Prenatal/Postnatal Care No charge

Rehabilitation Services \$50; 60 visits/yr comb PT/OT/ST

Chiropractic Care \$50

**Inpatient Services**

Inpatient Hospital \$500/day; 4 days/admit  
Inpatient Surgery No charge (physician's charges)  
Maternity Delivery/Inpatient \$500/day; 4 days/admit  
Mental Health Inpatient \$500/day; 4 days/admit  
Substance Abuse Inpatient \$500/day; 4 days/admit

**Outpatient Services**

Outpatient Facility \$500  
Outpatient Surgery No charge (physician's charges)  
Lab/X-Ray Lab-No charge; X-ray: Office-No charge; OP-\$100

Advanced Radiology Office-\$50; OP-\$200

Mental Health Outpatient \$50  
Substance Abuse Outpatient \$50

**Emergency Care**

Emergency Room \$400  
Ambulance \$400  
Urgent Care \$100

**Recovery/Special Needs**

Home Health Care \$50; 40 visits/yr  
Habilitation services \$50; 60 visits/yr comb PT/OT/ST

Skilled Nursing \$500/day; 4 days/admit

Durable Medical Equipment 10%  
Hospice Services 10%

**Miscellaneous Services**

Pediatric Vision Exam No charge  
Pediatric Vision Hardware No charge  
Pediatric Dental Check-Up No charge

Empire EPO/PPO  
Gold EPO 25/0%/6000\* (EPO) (UCR=N/A)

In-Network

Out-Network

**Prescription Drugs**

Drug Card 10/50/75

**Cost Share Information**

Individual/Family Deductible N/A  
Individual/Family OOP Limit \$6,000/\$12,000  
Co-Insurance 0%  
Lifetime Maximum None

**Office Visits**

Primary Care \$25

Specialist \$50  
Adult Preventive Care No charge  
Child Preventive Care No charge  
Maternity Prenatal/Postnatal Care No charge

Rehabilitation Services \$50; 60 visits/yr comb PT/OT/ST

Chiropractic Care \$50

**Inpatient Services**

Inpatient Hospital \$400/day; 4 days max/admit  
Inpatient Surgery No charge (physician's charges)  
Maternity Delivery/Inpatient \$400/day; 4 days max/admit  
Mental Health Inpatient \$400/day; 4 days max/admit  
Substance Abuse Inpatient \$400/day; 4 days max/admit

**Outpatient Services**

Outpatient Facility \$400  
Outpatient Surgery No charge (physician's charges)  
Lab/X-Ray Lab-No charge; X-ray: Office-No charge; OP-\$50

Advanced Radiology Office-\$50; OP-\$150

Mental Health Outpatient \$50  
Substance Abuse Outpatient \$50

**Emergency Care**

Emergency Room \$400  
Ambulance \$400  
Urgent Care \$75

**Recovery/Special Needs**

Home Health Care \$50; 40 visits/yr  
Habilitation services \$50; 60 visits/yr comb PT/OT/ST

Skilled Nursing \$400/day; 4 days max/admit

Durable Medical Equipment No charge  
Hospice Services No charge

**Miscellaneous Services**

Pediatric Vision Exam No charge  
Pediatric Vision Hardware No charge  
Pediatric Dental Check-Up No charge

HealthFirst Gold 25/50/0 Pro EPO* (EPO) (UCR=N/A)		
	In-Network	Out-Network
<b>Prescription Drugs</b>		
Drug Card	10/50/85	
<b>Cost Share Information</b>		
Individual/Family Deductible	N/A	
Individual/Family OOP Limit	\$7,000/\$14,000 (incl ded)	
Co-Insurance	0%	
Lifetime Maximum	None	
<b>Office Visits</b>		
Primary Care	\$25	
Specialist	\$50	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	\$50; 60 visits/cond/plan yr comb PT/OT/ST	
Chiropractic Care	\$50	
<b>Inpatient Services</b>		
Inpatient Hospital	\$500/admit	
Inpatient Surgery	\$100	
Maternity Delivery/Inpatient	Delivery-\$100; IP-\$500/admit	
Mental Health Inpatient	\$500/admit	
Substance Abuse Inpatient	\$500/admit	
<b>Outpatient Services</b>		
Outpatient Facility	\$300	
Outpatient Surgery	\$100	
Lab/X-Ray	PCP-\$25; SP-\$50	
Advanced Radiology	\$50	
Mental Health Outpatient	\$25	
Substance Abuse Outpatient	\$25	
<b>Emergency Care</b>		
Emergency Room	\$350 (waived if admitted)	
Ambulance	\$150	
Urgent Care	\$60	
<b>Recovery/Special Needs</b>		
Home Health Care	\$25; 40 visits/plan yr	
Habilitation services	\$50; 60 visits/cond/plan yr comb PT/OT/ST	
Skilled Nursing	\$500/admit; 200 days/plan yr	
Durable Medical Equipment	15%	
Hospice Services	\$500/admit IP; \$25 OP; 210 days/plan yr	
<b>Miscellaneous Services</b>		
Pediatric Vision Exam	\$10; 1 exam/yr	
Pediatric Vision Hardware	\$25; 1 pair/yr	
Pediatric Dental Check-Up	\$25; 2 visits/yr	

Oscar Circle  
Circle Gold \$0\* (EPOc) (UCR=N/A)

In-Network

Out-Network

	In-Network	Out-Network
<b>Prescription Drugs</b>		
Drug Card	10/25/100	
<b>Cost Share Information</b>		
Individual/Family Deductible	N/A	
Individual/Family OOP Limit	\$5,000/\$10,000	
Co-Insurance	20%	
Lifetime Maximum	None	
<b>Office Visits</b>		
Primary Care	\$25	
Specialist	\$50	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	\$25; 60 visits/cond/plan yr comb PT/OT/ST	
Chiropractic Care	\$25	
<b>Inpatient Services</b>		
Inpatient Hospital	\$500/day; 5 days/admit	
Inpatient Surgery	\$150	
Maternity Delivery/Inpatient	\$500/day; 5 days/admit	
Mental Health Inpatient	\$500/day; 5 days/admit	
Substance Abuse Inpatient	\$500/day; 5 days/admit	
<b>Outpatient Services</b>		
Outpatient Facility	\$150	
Outpatient Surgery	\$150	
Lab/X-Ray	\$50	
Advanced Radiology	\$125	
Mental Health Outpatient	\$25	
Substance Abuse Outpatient	\$25	
<b>Emergency Care</b>		
Emergency Room	\$750	
Ambulance	\$750	
Urgent Care	\$75	
<b>Recovery/Special Needs</b>		
Home Health Care	\$50; 40 visits/plan yr	
Habilitation services	\$25; 60 visits/cond/plan yr comb PT/OT/ST	
Skilled Nursing	\$500/day; 5 days/admit; 200 days/plan yr	
Durable Medical Equipment	20%	
Hospice Services	20%; 210 days/plan yr	
<b>Miscellaneous Services</b>		
Pediatric Vision Exam	\$50; 1 exam/12 mo	
Pediatric Vision Hardware	20%; 1 pair/12 mo	
Pediatric Dental Check-Up	No charge; 1 exam/6 mo	

Oscar Circle Plus  
Circle Plus Gold \$0\* (EPOc) (UCR=N/A)

In-Network

Out-Network

**Prescription Drugs**

Drug Card 10/25/100

**Cost Share Information**

Individual/Family Deductible N/A  
Individual/Family OOP Limit \$5,000/\$10,000  
Co-Insurance 20%  
Lifetime Maximum None

**Office Visits**

Primary Care \$25

Specialist \$50  
Adult Preventive Care No charge  
Child Preventive Care No charge  
Maternity Prenatal/Postnatal Care No charge

Rehabilitation Services \$25; 60 visits/cond/plan yr comb PT/OT/ST

Chiropractic Care \$25

**Inpatient Services**

Inpatient Hospital \$500/day; 5 days/admit  
Inpatient Surgery \$150  
Maternity Delivery/Inpatient \$500/day; 5 days/admit  
Mental Health Inpatient \$500/day; 5 days/admit  
Substance Abuse Inpatient \$500/day; 5 days/admit

**Outpatient Services**

Outpatient Facility \$150  
Outpatient Surgery \$150  
Lab/X-Ray \$50

Advanced Radiology \$125  
Mental Health Outpatient \$25  
Substance Abuse Outpatient \$25

**Emergency Care**

Emergency Room \$750  
Ambulance \$750  
Urgent Care \$75

**Recovery/Special Needs**

Home Health Care \$50; 40 visits/plan yr  
Habilitation services \$25; 60 visits/cond/plan yr comb PT/OT/ST

Skilled Nursing \$500/day; 5 days/admit; 200 days/plan yr

Durable Medical Equipment 20%  
Hospice Services 20%; 210 days/plan yr

**Miscellaneous Services**

Pediatric Vision Exam \$50; 1 exam/12 mo  
Pediatric Vision Hardware 20%; 1 pair/12 mo  
Pediatric Dental Check-Up No charge; 1 exam/6 mo

Oxford Metro  
M Gold EPO 25/40 Non-Gated OHI CNT\* (EPOc) (UCR=N/A)

In-Network

Out-Network

**Prescription Drugs**

Drug Card 10/65/90/100 ded T2-3

**Cost Share Information**

Individual/Family Deductible \$1,250/\$2,500  
Individual/Family OOP Limit \$5,000/\$10,000 (incl ded)  
Co-Insurance 20%  
Lifetime Maximum None

**Office Visits**

Primary Care \$25 ded waived

Specialist \$40 ded waived

Adult Preventive Care No charge

Child Preventive Care No charge

Maternity Prenatal/Postnatal Care No charge

Rehabilitation Services \$40 ded waived; 60 visits/cal yr comb PT/OT/ST

Chiropractic Care \$40 ded waived

**Inpatient Services**

Inpatient Hospital 20% after ded

Inpatient Surgery 20% after ded

Maternity Delivery/Inpatient 20% after ded

Mental Health Inpatient 20% after ded

Substance Abuse Inpatient Rehab-20% after ded

**Outpatient Services**

Outpatient Facility Hosp-\$500 after ded; FS-\$200 after ded

Outpatient Surgery 20% after ded

Lab/X-Ray Lab-\$15 ded waived; X-ray-\$50 after ded

Advanced Radiology \$150 after ded

Mental Health Outpatient \$40 ded waived

Substance Abuse Outpatient Rehab-\$40 ded waived

**Emergency Care**

Emergency Room \$400 (waived if admitted) ded waived

Ambulance No charge

Urgent Care \$65 ded waived

**Recovery/Special Needs**

Home Health Care \$40 ded waived; 40 visits/cal yr

Habilitation services \$40 ded waived; 60 visits/cal yr comb PT/OT/ST

Skilled Nursing 20% after ded; 200 days/cal yr

Durable Medical Equipment 20% after ded

Hospice Services 20% after ded

**Miscellaneous Services**

Pediatric Vision Exam \$25 ded waived

Pediatric Vision Hardware 50% ded waived

Pediatric Dental Check-Up 0% after ded

Oxford Liberty  
L Gold EPO 30/60 Gated OHI CNT\* (EPOc) (UCR=N/A)

In-Network

Out-Network

**Prescription Drugs**

Drug Card 15/35/75/100 ded T2-3

**Cost Share Information**

Individual/Family Deductible \$1,000/\$2,000  
Individual/Family OOP Limit \$4,500/\$9,000 (incl ded)  
Co-Insurance 0%  
Lifetime Maximum None

**Office Visits**

Primary Care \$30 ded waived

Specialist \$60 ded waived

Adult Preventive Care No charge

Child Preventive Care No charge

Maternity Prenatal/Postnatal Care No charge

Rehabilitation Services \$60 ded waived; 60 visits/cal yr comb PT/OT/ST

Chiropractic Care \$60 ded waived

**Inpatient Services**

Inpatient Hospital \$500/day after ded; \$2,000 max/admit  
Inpatient Surgery 0% after ded  
Maternity Delivery/Inpatient \$500/day after ded; \$2,000 max/admit  
Mental Health Inpatient \$500/day after ded; \$2,000 max/admit  
Substance Abuse Inpatient Rehab-\$500/day after ded; \$2,000 max/admit

**Outpatient Services**

Outpatient Facility Hosp-\$250 after ded; FS-\$150 after ded  
Outpatient Surgery Included in Outpatient Facility  
Lab/X-Ray Lab-No charge; X-ray-\$35 after ded

Advanced Radiology \$100 after ded  
Mental Health Outpatient \$60 ded waived  
Substance Abuse Outpatient Rehab-\$60 ded waived

**Emergency Care**

Emergency Room \$500 (waived if admitted) ded waived  
Ambulance No charge  
Urgent Care \$75 ded waived

**Recovery/Special Needs**

Home Health Care \$60 ded waived; 40 visits/cal yr  
Habilitation services \$60 ded waived; 60 visits/cal yr comb PT/OT/ST

Skilled Nursing \$500/day after ded; \$2,000 max/admit; 200 days/cal yr

Durable Medical Equipment 0% after ded  
Hospice Services \$500/day after ded; \$2,000 max/admit

**Miscellaneous Services**

Pediatric Vision Exam \$30 ded waived  
Pediatric Vision Hardware 50% ded waived  
Pediatric Dental Check-Up 0% after ded

Oxford Freedom  
F Gold EPO 15/35 Non-Gated OHI CNT\* (EPOc) (UCR=N/A)

In-Network

Out-Network

**Prescription Drugs**

Drug Card 15/35/75/100 ded T2-3

**Cost Share Information**

Individual/Family Deductible \$1,000/\$2,000  
Individual/Family OOP Limit \$5,250/\$10,500 (incl ded)  
Co-Insurance 10%  
Lifetime Maximum None

**Office Visits**

Primary Care \$15 ded waived

Specialist \$35 ded waived

Adult Preventive Care No charge

Child Preventive Care No charge

Maternity Prenatal/Postnatal Care No charge

Rehabilitation Services \$35 ded waived; 60 visits/cal yr comb PT/OT/ST

Chiropractic Care \$35 ded waived

**Inpatient Services**

Inpatient Hospital 10% after ded

Inpatient Surgery 10% after ded

Maternity Delivery/Inpatient 10% after ded

Mental Health Inpatient 10% after ded

Substance Abuse Inpatient Rehab-10% after ded

**Outpatient Services**

Outpatient Facility Hosp-\$300 after ded; FS-\$150 after ded

Outpatient Surgery 10% after ded

Lab/X-Ray Lab-No charge; X-ray-\$80 after ded

Advanced Radiology \$150 after ded

Mental Health Outpatient \$35 ded waived

Substance Abuse Outpatient Rehab-\$35 ded waived

**Emergency Care**

Emergency Room \$500 (waived if admitted) ded waived

Ambulance No charge

Urgent Care \$75 ded waived

**Recovery/Special Needs**

Home Health Care \$35 ded waived; 40 visits/cal yr

Habilitation services \$35 ded waived; 60 visits/cal yr comb PT/OT/ST

Skilled Nursing 10% after ded; 200 days/cal yr

Durable Medical Equipment 10% after ded

Hospice Services 10% after ded

**Miscellaneous Services**

Pediatric Vision Exam \$15 ded waived

Pediatric Vision Hardware 50% ded waived

Pediatric Dental Check-Up 0% after ded