

| | Aetna Gold OAEPO 1000 90% ID: 14041846* (EPOc) (UCR=N/A) | EmblemHealth EH Gold Premier NG Prime* (HMOc) (UCR=N/A) | EmblemHealth EH Gold Choice NG Select Care* (HMOc) (UCR=N/A) | Empire Blue Access Gold Blue Access EPO 35/10%/5850* (EPOc) (UCR=N/A) | Empire EPO/PPO Gold EPO 25/0%/6000* (EPO) (UCR=N/A) | HealthFirst Gold 25/50/0 Pro EPO* (EPO) (UCR=N/A) | Oscar Circle Circle Gold \$0* (EPOc) (UCR=N/A) | Oscar Circle Plus Circle Plus Gold \$0* (EPOc) (UCR=N/A) |
|---------------------------|---|--|---|--|--|--|---|---|
| Prescription Drugs | | | | | | | | |
| 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 |
| In-Network | | | | | | | | |
| 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 |
| Out-Network | | | | | | | | |
| Ind/Fam Deductible | | | | | | | | |
| Ind/Fam OOP Limit | | | | | | | | |
| Co-Insurance | | | | | | | | |
| Primary Care | | | | | | | | |
| Specialist | | | | | | | | |
| Inpatient Hospital | | | | | | | | |
| Single | 0 x \$1,008.74 | 0 x \$918.78 | 0 x \$782.09 | 0 x \$897.09 | 0 x \$976.86 | 0 x \$744.15 | 0 x \$734.02 | 0 x \$819.18 |
| EE with Spouse | 0 x \$2,017.49 | 0 x \$1,837.55 | 0 x \$1,564.17 | 0 x \$1,794.18 | 0 x \$1,953.72 | 0 x \$1,488.30 | 0 x \$1,468.05 | 0 x \$1,638.37 |
| EE with Child(ren) | 0 x \$1,714.86 | 0 x \$1,561.92 | 0 x \$1,329.55 | 0 x \$1,525.05 | 0 x \$1,660.66 | 0 x \$1,265.06 | 0 x \$1,247.84 | 0 x \$1,392.61 |
| Family | 0 x \$2,874.92 | 0 x \$2,618.51 | 0 x \$2,228.94 | 0 x \$2,556.71 | 0 x \$2,784.05 | 0 x \$2,120.83 | 0 x \$2,091.97 | 0 x \$2,334.67 |
| Monthly Cost | 0 \$0.00 | 0 \$0.00 | 0 \$0.00 | 0 \$0.00 | 0 \$0.00 | 0 \$0.00 | 0 \$0.00 | 0 \$0.00 |
| Annual Cost | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |

| | Oxford Metro M Gold EPO 25/40 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 | \$5,500/\$11,000 (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 | | | |
| Single | 0 x \$705.49 | 0 x \$840.72 | 0 x \$936.72 |
| EE with Spouse | 0 x \$1,410.98 | 0 x \$1,681.45 | 0 x \$1,873.44 |
| EE with Child(ren) | 0 x \$1,199.33 | 0 x \$1,429.24 | 0 x \$1,592.43 |
| Family | 0 x \$2,010.64 | 0 x \$2,396.07 | 0 x \$2,669.65 |
| Monthly Cost | 0 \$0.00 | 0 \$0.00 | 0 \$0.00 |
| Annual Cost | \$0.00 | \$0.00 | \$0.00 |

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 |
| Prescription Drugs | | |
| Drug Card | 10/30/70 | |
| Cost Share Information | | |
| Individual/Family Deductible | \$450/\$900 | |
| Individual/Family OOP Limit | \$4,000/\$8,000 (incl ded) | |
| Co-Insurance | 0% | |
| Lifetime Maximum | None | |
| Office Visits | | |
| 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 | |
| Inpatient Services | | |
| 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 | |
| Outpatient Services | | |
| 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 | |
| Emergency Care | | |
| Emergency Room | \$300 (waived if admitted) after ded | |
| Ambulance | \$150 after ded | |
| Urgent Care | \$75 ded waived | |
| Recovery/Special Needs | | |
| 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 | |
| Miscellaneous Services | | |
| 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 |
| Prescription Drugs | | |
| Drug Card | 20/45/75 IntDed T2-3 | |
| Cost Share Information | | |
| Individual/Family Deductible | \$750/\$1,500 | |
| Individual/Family OOP Limit | \$5,000/\$10,000 (incl ded) | |
| Co-Insurance | 0% | |
| Lifetime Maximum | None | |
| Office Visits | | |
| 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 | |
| Inpatient Services | | |
| 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 | |
| Outpatient Services | | |
| 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 | |
| Emergency Care | | |
| Emergency Room | \$300 (waived if admitted) after ded | |
| Ambulance | \$150 after ded | |
| Urgent Care | \$75 ded waived | |
| Recovery/Special Needs | | |
| 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 | |
| Miscellaneous Services | | |
| 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 |
| Prescription Drugs | | |
| Drug Card | 10/50/85 | |
| Cost Share Information | | |
| Individual/Family Deductible | N/A | |
| Individual/Family OOP Limit | \$7,000/\$14,000 (incl ded) | |
| 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/cond/plan yr comb PT/OT/ST | |
| Chiropractic Care | \$50 | |
| Inpatient Services | | |
| 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 | |
| Outpatient Services | | |
| Outpatient Facility | \$300 | |
| Outpatient Surgery | \$100 | |
| Lab/X-Ray | PCP-\$25; SP-\$50 | |
| Advanced Radiology | \$50 | |
| Mental Health Outpatient | \$25 | |
| Substance Abuse Outpatient | \$25 | |
| Emergency Care | | |
| Emergency Room | \$350 (waived if admitted) | |
| Ambulance | \$150 | |
| Urgent Care | \$60 | |
| Recovery/Special Needs | | |
| 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 | |
| Miscellaneous Services | | |
| 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 |
| 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 | |

| 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 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 \$5,500/\$11,000 (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 \$500 (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