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2017 SMALL GROUP HEALTH INSURANCE RATES

3Q - Long Island - Effective 7/1/2017

	Aetna		CareConnect		EmblemHealth		Empire EPO/PPO (BlueCard)	
	Gold OAEPO 1000 90% ID: 14034164*		Tradition Gold Copay*		Select Care Gold HMO 40/60*		Gold EPO 500/20%/7150*	
	In-Network	Out-Network	In-Network	Out-Network	In-Network		In-Network	Out-Network
Prescription Drugs								
Drug Card	20/40/60/TCS/100 ded T2-T4		15/35/75/100 ded T2-3		15/35/75/100 ded		10/35/75	
Cost Share Information								
Individual/Family Deductible	$1,000/$2,000 embedded		N/A		$250/$500		$500/$1,500 embedded	
Individual/Family OOP Limit	$5,000/$10,000 (incl ded)		$7,150/$14,300		$5,500/$11,000 (incl ded)		$7,150/$14,300 (incl ded)	
Co-Insurance	10%		0%		0%		20%	
Office Visits								
Primary Care	$30 ded waived		$30		$40 after ded		$25 ded waived	
Specialist	$60 ded waived		$50		$60 after ded		$50 ded waived	
Inpatient Services								
Inpatient Hospital	10% after ded		$500/day; $1,500 max/admit		$1,500/admit after ded; pre-auth req		20% after ded	
Mental Health Inpatient	10% after ded		$500/day; $1,500 max/admit		$1,500/admit after ded; pre-auth req		20% after ded	
Outpatient Services								
Outpatient Facility	Refer to Outpatient Surgery		$300		$150 after ded; pre-auth req		20% after ded	
Lab/X-Ray	10% after ded		$30		PCP-$40 after ded; SP-$60 after ded		20% after ded	
Mental Health Outpatient	$60 ded waived		$30		$40 after ded		$50 ded waived	
Emergency Care								
Emergency Room	$500 (waived if admitted) ded waived		$350 (waived if admitted)		$200 (waived if admitted) after ded		$300 ded waived	
Urgent Care	$75 ded waived		$50		$60 after ded		$75 ded waived	
Single	0 x	$859.60	0 x	$650.00	0 x	$798.50	0 x	$853.66
EE with Spouse	0 x	$1,719.20	0 x	$1,300.00	0 x	$1,597.00	0 x	$1,707.32
EE with Child(ren)	0 x	$1,461.32	0 x	$1,105.00	0 x	$1,357.46	0 x	$1,451.22
Family	0 x	$2,449.86	0 x	$1,853.00	0 x	$2,275.73	0 x	$2,432.93
Monthly Cost	0	$0.00	0	$0.00	0	$0.00	0	$0.00
Annual Cost		$0.00		$0.00		$0.00		$0.00

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	HealthFirst		Oscar		Oxford Freedom		Oxford Liberty	
	Gold Pro Plus EPO Adult Dental/Vision*		Simple Gold*		F Gold EPO 25/40 Non-Gated OHI CNT*		L Gold EPO 30/60 Gated OHI CNT*	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	20/50/50%to$500		0/50/0%/0% IntDed T3-4		15/35/75/100 ded T2-3		15/35/75/100 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$1,000/$2,000		$3,000/$6,000		$1,250/$2,500		$1,000/$2,000	
Individual/Family OOP Limit	$3,500/$7,000 (incl ded)		$3,000/$6,000 (incl ded)		$5,000/$10,000 (incl ded)		$4,000/$8,000 (incl ded)	
Co-Insurance	20%		0%		20%		0%	
Office Visits								
Primary Care	$25 ded waived		$10 ded waived		$25 ded waived		$30 ded waived	
Specialist	$40 ded waived		$50 ded waived		$40 ded waived		$60 ded waived	
Inpatient Services								
Inpatient Hospital	20% after ded		0% after ded		20% after ded		$500/day after ded; $2,000 max/admit	
Mental Health Inpatient	20% after ded		0% after ded		20% after ded		$500/day after ded; $2,000 max/admit	
Outpatient Services								
Outpatient Facility	$300 after ded		0% after ded		Hosp-$250 after ded; FS-$150 after ded		Hosp-$250 after ded; FS-$150 after ded	
Lab/X-Ray	PCP-$25 ded waived; SP-$40 ded waived		Lab-$25 ded waived; X-ray-0% after ded		Lab-No charge; X-ray-$80 after ded		Lab-No charge; X-ray-$35 after ded	
Mental Health Outpatient	$25 ded waived		$50 ded waived		$40 ded waived		$60 ded waived	
Emergency Care								
Emergency Room	$300 (waived if admitted) after ded		0% after ded		$400 (waived if admitted) ded waived		$200 (waived if admitted) ded waived	
Urgent Care	$60 ded waived		$100 ded waived		$75 ded waived		$75 ded waived	

Single	0 x	$729.19	0 x	$714.84	0 x	$829.11	0 x	$804.49
EE with Spouse	0 x	$1,458.37	0 x	$1,429.67	0 x	$1,658.22	0 x	$1,608.98
EE with Child(ren)	0 x	$1,239.62	0 x	$1,215.22	0 x	$1,409.49	0 x	$1,367.63
Family	0 x	$2,078.18	0 x	$2,037.28	0 x	$2,362.96	0 x	$2,292.80
Monthly Cost	0	$0.00	0	$0.00	0	$0.00	0	$0.00
Annual Cost		$0.00		$0.00		$0.00		$0.00

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	Oxford Metro	
	M Gold EPO 15/30 Gated OHI CNT*	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/65/50%to$800	
Cost Share Information		
Individual/Family Deductible	$750/$1,500	
Individual/Family OOP Limit	$4,000/$8,000 (incl ded)	
Co-Insurance	20%	
Office Visits		
Primary Care	$15 ded waived	
Specialist	$30 ded waived	
Inpatient Services		
Inpatient Hospital	20% after ded	
Mental Health Inpatient	20% after ded	
Outpatient Services		
Outpatient Facility	Hosp-$500 after ded; FS-$200 after ded	
Lab/X-Ray	Lab-No charge; X-ray-$50 after ded	
Mental Health Outpatient	$30 ded waived	
Emergency Care		
Emergency Room	$400 (waived if admitted) ded waived	
Urgent Care	$65 ded waived	

Single	0 x	$713.28
EE with Spouse	0 x	$1,426.56
EE with Child(ren)	0 x	$1,212.58
Family	0 x	$2,032.85
Monthly Cost	0	$0.00
Annual Cost		$0.00

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	Aetna Gold OAEPO 1000 90% ID: 14034164* (EPOc) (UCR=N/A)	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	20/40/60/TCS/100 ded T2-T4	
Cost Share Information		
Individual/Family Deductible	$1,000/$2,000 embedded	
Individual/Family OOP Limit	$5,000/$10,000 (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	$500 (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; 200 days/cal yr	
Durable Medical Equipment	50% after ded	
Hospice Services	10% after ded	
Miscellaneous Services		
Pediatric Vision Exam	No charge; 1 exam/12 mo	
Pediatric Vision Hardware	No charge; 1 pair/12 mo	
Pediatric Dental Check-Up	No charge; 1 exam/6 mo	

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	CareConnect Tradition Gold Copay* (EPO) (UCR=N/A)	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	15/35/75/100 ded T2-3	
Cost Share Information		
Individual/Family Deductible	N/A	
Individual/Family OOP Limit	$7,150/$14,300	
Co-Insurance	0%	
Lifetime Maximum	None	
Office Visits		
Primary Care	$30	
Specialist	$50	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	$30; 60 visits/cond/yr comb PT/OT/ST	
Chiropractic Care	$50	
Inpatient Services		
Inpatient Hospital	$500/day; $1,500 max/admit	
Inpatient Surgery	$500	
Maternity Delivery/Inpatient	$500/day; $1,500 max/admit	
Mental Health Inpatient	$500/day; $1,500 max/admit	
Substance Abuse Inpatient	$500/day; $1,500 max/admit	
Outpatient Services		
Outpatient Facility	$300	
Outpatient Surgery	$500	
Lab/X-Ray	$30	
Advanced Radiology	$100	
Mental Health Outpatient	$30	
Substance Abuse Outpatient	$30	
Emergency Care		
Emergency Room	$350 (waived if admitted)	
Ambulance	$150	
Urgent Care	$50	
Recovery/Special Needs		
Home Health Care	$30; 40 visits/yr	
Habilitation services	$30; 60 visits/cond/yr comb PT/OT/ST	
Skilled Nursing	$500/day; $1,500 max/admit; 200 days/yr	
Durable Medical Equipment	No charge	
Hospice Services	$500/day; $1,500 max/admit IP; $30 OP; 210 days/yr	
Miscellaneous Services		
Pediatric Vision Exam	$30; 1 exam/yr	
Pediatric Vision Hardware	20%; 1 pair/yr	
Pediatric Dental Check-Up	$30; 2 exams/12 mo	

2017 SMALL GROUP HEALTH INSURANCE RATES

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	EmblemHealth Select Care Gold HMO 40/60* (HMOc) (UCR=N/A)	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	15/35/75/100 ded	
Cost Share Information		
Individual/Family Deductible	$250/$500	
Individual/Family OOP Limit	$5,500/$11,000 (incl ded)	
Co-Insurance	0%	
Lifetime Maximum	None	
Office Visits		
Primary Care	$40 after ded	
Specialist	$60 after ded	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	$60 after ded; 90 visits/cond/plan yr comb PT/OT/ST; pre-auth req	
Chiropractic Care	$60 after ded	
Inpatient Services		
Inpatient Hospital	$1,500/admit after ded; pre-auth req	
Inpatient Surgery	No charge; pre-auth req	
Maternity Delivery/Inpatient	Delivery-No charge; IP-$1,500/admit after ded; pre-auth req	
Mental Health Inpatient	$1,500/admit after ded; pre-auth req	
Substance Abuse Inpatient	$1,500/admit after ded; pre-auth req	
Outpatient Services		
Outpatient Facility	$150 after ded; pre-auth req	
Outpatient Surgery	No charge; pre-auth req	
Lab/X-Ray	PCP-$40 after ded; SP-$60 after ded	
Advanced Radiology	$60 after ded	
Mental Health Outpatient	$40 after ded	
Substance Abuse Outpatient	$40 after ded	
Emergency Care		
Emergency Room	$200 (waived if admitted) after ded	
Ambulance	$100 after ded	
Urgent Care	$60 after ded	
Recovery/Special Needs		
Home Health Care	$40 after ded; 40 visits/plan yr; pre-auth req	
Habilitation services	$60 after ded; 90 visits/cond/plan yr comb PT/OT/ST; pre-auth req	
Skilled Nursing	$1,500/admit after ded; 365 days/plan yr; pre-auth req	
Durable Medical Equipment	10% after ded; pre-auth req	
Hospice Services	$1,500/admit after ded IP; $40 after ded OP; 210 days/plan yr; pre-auth req	
Miscellaneous Services		
Pediatric Vision Exam	$40 after ded; 1 exam/12 mo	
Pediatric Vision Hardware	10% after ded; 1 pair/12 mo	
Pediatric Dental Check-Up	$40 after ded; 1 exam/6 mo	

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	Empire EPO/PPO (BlueCard) Gold EPO 500/20%/7150* (EPOc) (UCR=N/A)	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/35/75	
Cost Share Information		
Individual/Family Deductible	$500/$1,500 embedded	
Individual/Family OOP Limit	$7,150/$14,300 (incl ded)	
Co-Insurance	20%	
Lifetime Maximum	None	
Office Visits		
Primary Care	$25 ded waived	
Specialist	$50 ded waived	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	Pre-No charge; Post-20% after ded	
Rehabilitation Services	$50 ded waived; 60 visits/yr comb PT/OT/ST	
Chiropractic Care	$50 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	20% after ded	
Outpatient Services		
Outpatient Facility	20% after ded	
Outpatient Surgery	20% after ded	
Lab/X-Ray	20% after ded	
Advanced Radiology	20% after ded	
Mental Health Outpatient	$50 ded waived	
Substance Abuse Outpatient	$50 ded waived	
Emergency Care		
Emergency Room	$300 ded waived	
Ambulance	20% after ded	
Urgent Care	$75 ded waived	
Recovery/Special Needs		
Home Health Care	$50 ded waived; 40 visits/yr	
Habilitation services	$50 ded waived; 60 visits/yr comb PT/OT/ST	
Skilled Nursing	20% after ded; 200 days/yr	
Durable Medical Equipment	20% after ded	
Hospice Services	20% after ded	
Miscellaneous Services		
Pediatric Vision Exam	No charge	
Pediatric Vision Hardware	No charge	
Pediatric Dental Check-Up	0% after ded	

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	HealthFirst Gold Pro Plus EPO Adult Dental/Vision* (EPOc) (UCR=N/A)	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	20/50/50%to$500	
Cost Share Information		
Individual/Family Deductible	$1,000/$2,000	
Individual/Family OOP Limit	$3,500/$7,000 (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/cond/plan 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	Delivery-$100 after ded; IP-20% after ded	
Mental Health Inpatient	20% after ded	
Substance Abuse Inpatient	20% after ded	
Outpatient Services		
Outpatient Facility	$300 after ded	
Outpatient Surgery	$300 after ded	
Lab/X-Ray	PCP-$25 ded waived; SP-$40 ded waived	
Advanced Radiology	$40 after ded	
Mental Health Outpatient	$25 ded waived	
Substance Abuse Outpatient	$25 ded waived	
Emergency Care		
Emergency Room	$300 (waived if admitted) after ded	
Ambulance	$150 after ded	
Urgent Care	$60 ded waived	
Recovery/Special Needs		
Home Health Care	$25 after ded; 40 visits/plan yr	
Habilitation services	$40 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	
Skilled Nursing	20% after ded; 200 days/plan yr	
Durable Medical Equipment	20% after ded	
Hospice Services	20% after ded IP; $25 ded waived OP; 210 days/plan yr	
Miscellaneous Services		
Pediatric Vision Exam	$10 ded waived; 1 exam/yr (includes adults)	
Pediatric Vision Hardware	$25 ded waived; 1 pair/yr (includes adults)	
Pediatric Dental Check-Up	$25 ded waived; 2 visits/yr (includes adults)	

2017 SMALL GROUP HEALTH INSURANCE RATES

3Q - Long Island - Effective 7/1/2017

	Oscar Simple Gold* (EPOc) (UCR=N/A)	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	0/50/0%/0% IntDed T3-4	
Cost Share Information		
Individual/Family Deductible	$3,000/$6,000	
Individual/Family OOP Limit	$3,000/$6,000 (incl ded)	
Co-Insurance	0%	
Lifetime Maximum	None	
Office Visits		
Primary Care	$10 ded waived	
Specialist	$50 ded waived	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	$50 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	
Chiropractic Care	$50 ded waived	
Inpatient Services		
Inpatient Hospital	0% after ded	
Inpatient Surgery	0% after ded	
Maternity Delivery/Inpatient	0% after ded	
Mental Health Inpatient	0% after ded	
Substance Abuse Inpatient	0% after ded	
Outpatient Services		
Outpatient Facility	0% after ded	
Outpatient Surgery	0% after ded	
Lab/X-Ray	Lab-$25 ded waived; X-ray-0% after ded	
Advanced Radiology	0% after ded	
Mental Health Outpatient	$50 ded waived	
Substance Abuse Outpatient	$50 ded waived	
Emergency Care		
Emergency Room	0% after ded	
Ambulance	0% after ded	
Urgent Care	$100 ded waived	
Recovery/Special Needs		
Home Health Care	$50 ded waived; 40 visits/plan yr	
Habilitation services	$50 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	
Skilled Nursing	0% after ded; 200 days/plan yr	
Durable Medical Equipment	0% after ded	
Hospice Services	0% after ded; 210 days/yr	
Miscellaneous Services		
Pediatric Vision Exam	$50 ded waived; 1 exam/12 mo	
Pediatric Vision Hardware	0% after ded; 1 pair/12 mo	
Pediatric Dental Check-Up	0% after ded; 1 exam/6 mo	

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	Oxford Freedom F Gold EPO 25/40 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	$1,250/$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/contr 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-$250 after ded; FS-$150 after ded	
Outpatient Surgery	Included in Outpatient Facility	
Lab/X-Ray	Lab-No charge; X-ray-$80 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	$75 ded waived	
Recovery/Special Needs		
Home Health Care	$40 ded waived; 40 visits/contr yr	
Habilitation services	$40 ded waived; 60 visits/contr yr comb PT/OT/ST	
Skilled Nursing	20% after ded; 200 days/contr yr	
Durable Medical Equipment	20% after ded	
Hospice Services	20% after ded IP; $40 ded waived OP	
Miscellaneous Services		
Pediatric Vision Exam	$25 ded waived	
Pediatric Vision Hardware	50% ded waived	
Pediatric Dental Check-Up	0% after ded	

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	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	$4,000/$8,000 (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/contr 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	$200 (waived if admitted) ded waived	
Ambulance	No charge	
Urgent Care	$75 ded waived	
Recovery/Special Needs		
Home Health Care	$60 ded waived; 40 visits/contr yr	
Habilitation services	$60 ded waived; 60 visits/contr yr comb PT/OT/ST	
Skilled Nursing	$500/day after ded; $2,000 max/admit; 200 days/contr yr	
Durable Medical Equipment	0% after ded	
Hospice Services	$500/day after ded; $2,000 max/admit IP; $60 ded waived OP	
Miscellaneous Services		
Pediatric Vision Exam	$30 ded waived	
Pediatric Vision Hardware	50% ded waived	
Pediatric Dental Check-Up	0% after ded	

2017 SMALL GROUP HEALTH INSURANCE RATES

3Q - Long Island - Effective 7/1/2017

	Oxford Metro M Gold EPO 15/30 Gated OHI CNT* (EPOc) (UCR=N/A)	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/65/50%to$800	
Cost Share Information		
Individual/Family Deductible	$750/$1,500	
Individual/Family OOP Limit	$4,000/$8,000 (incl ded)	
Co-Insurance	20%	
Lifetime Maximum	None	
Office Visits		
Primary Care	$15 ded waived	
Specialist	$30 ded waived	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	$30 ded waived; 60 visits/contr yr comb PT/OT/ST	
Chiropractic Care	$30 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	Included in Outpatient Facility	
Lab/X-Ray	Lab-No charge; X-ray-$50 after ded	
Advanced Radiology	$150 after ded	
Mental Health Outpatient	$30 ded waived	
Substance Abuse Outpatient	Rehab-$30 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	$30 ded waived; 40 visits/contr yr	
Habilitation services	$30 ded waived; 60 visits/contr yr comb PT/OT/ST	
Skilled Nursing	20% after ded; 200 days/contr yr	
Durable Medical Equipment	20% after ded	
Hospice Services	20% after ded IP; $30 ded waived OP	
Miscellaneous Services		
Pediatric Vision Exam	$15 ded waived	
Pediatric Vision Hardware	50% ded waived	
Pediatric Dental Check-Up	0% after ded	