



|                           | <b>Aetna<br/>Gold EPO 1000 90% ID:<br/>14038844* (EPOc)<br/>(UCR=N/A)</b> | <b>EmblemHealth<br/>EmblemHealth Gold<br/>40/60* (HMOc)<br/>(UCR=N/A)</b> | <b>Empire Blue Priority<br/>Gold Blue Priority EPO<br/>35/10%/5850* (EPOc)<br/>(UCR=N/A)</b> | <b>Empire EPO/PPO<br/>Gold EPO 500/20%/7350*<br/>(EPOc) (UCR=N/A)</b> | <b>HealthFirst<br/>Gold Pro EPO* (EPOc)<br/>(UCR=N/A)</b> | <b>Oscar<br/>Classic Gold 0 * (EPO)<br/>(UCR=N/A)</b> | <b>Oxford Metro<br/>M Gold EPO 25/40 Gated<br/>OHI CNT* (EPOc)<br/>(UCR=N/A)</b> | <b>Oxford Liberty<br/>L Gold EPO 30/60 Gated<br/>OHI CNT* (EPOc)<br/>(UCR=N/A)</b> |
|---------------------------|---|---|--|---|---|---|--|--|
| <b>Prescription Drugs</b> |   |   |  |   |   |   |  |  |
| Drug Card                 | 15/65/50%/TCS/100 ded T2-4  | 15/35/75/100 ded  | 10/35/75   | 10/35/75  | 10/50/85  | 10/50/100   | 10/65/50%to\$800   | 15/35/75/100 ded T2-3  |
| <b>In-Network</b>         |   |   |  |   |   |   |  |  |
| Ind/Fam Deductible        | \$1,000/\$2,000 embedded  | \$250/\$500   | N/A  | \$500/\$1,500 embedded  | N/A   | N/A   | \$1,250/\$2,500  | \$1,000/\$2,000  |
| Ind/Fam OOP Limit         | \$6,000/\$12,000 (incl ded)   | \$5,500/\$11,000 (incl ded)   | \$5,850/\$11,700   | \$7,350/\$14,700 (incl ded)   | \$5,000/\$10,000 (incl ded)                               | \$5,000/\$10,000 (incl ded)                           | \$5,500/\$11,000 (incl ded)  | \$4,000/\$8,000 (incl ded)   |
| Co-Insurance              | 10%   | 0%  | 10%  | 20%   | 0%  | 0%  | 20%  | 0%   |
| Primary Care              | \$30 ded waived   | \$40 after ded  | \$35   | \$25 ded waived   | \$25  | \$25  | \$25 ded waived  | \$30 ded waived  |
| Specialist                | \$60 ded waived   | \$60 after ded  | \$50   | \$50 ded waived   | \$40  | \$50  | \$40 ded waived  | \$60 ded waived  |
| Inpatient Hospital        | 10% after ded   | \$1,500/admit after ded;<br>pre-auth req                                  | \$500/day; 4 days/admit  | 20% after ded   | \$500/day; \$1,500 max/admit                              | \$500/admit   | 20% after ded  | \$500/day after ded; \$2,000<br>max/admit  |
| <b>Out-Network</b>        |   |   |  |   |   |   |  |  |
| Ind/Fam Deductible        |   |   |  |   |   |   |  |  |
| Ind/Fam OOP Limit         |   |   |  |   |   |   |  |  |
| Co-Insurance              |   |   |  |   |   |   |  |  |
| Primary Care              |   |   |  |   |   |   |  |  |
| Specialist                |   |   |  |   |   |   |  |  |
| Inpatient Hospital        |   |   |  |   |   |   |  |  |
| <b>Single</b>             | 0 x \$905.99  | 0 x \$852.74  | 0 x \$854.95   | 0 x \$894.50  | 0 x \$728.03  | 0 x \$731.50  | 0 x \$700.96   | 0 x \$843.04   |
| <b>EE with Spouse</b>     | 0 x \$1,811.98  | 0 x \$1,705.49  | 0 x \$1,709.90   | 0 x \$1,789.00  | 0 x \$1,456.06  | 0 x \$1,463.00  | 0 x \$1,401.92   | 0 x \$1,686.08   |
| <b>EE with Child(ren)</b> | 0 x \$1,540.18  | 0 x \$1,449.67  | 0 x \$1,453.42   | 0 x \$1,520.65  | 0 x \$1,237.65  | 0 x \$1,243.55  | 0 x \$1,191.63   | 0 x \$1,433.17   |
| <b>Family</b>             | 0 x \$2,582.07  | 0 x \$2,430.31  | 0 x \$2,436.61   | 0 x \$2,549.33  | 0 x \$2,074.89  | 0 x \$2,084.77  | 0 x \$1,997.73   | 0 x \$2,402.67   |
| <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 Freedom<br>F Gold EPO 15/35<br>Non-Gated OHI CNT*<br>(EPOc) (UCR=N/A) |                            |
|--|----------------------------|
| <b>Prescription Drugs</b>  |                            |
| Drug Card  | 15/35/75/100 ded T2-3      |
| <b>In-Network</b>  |                            |
| Ind/Fam Deductible   | \$1,000/\$2,000            |
| Ind/Fam OOP Limit  | \$4,000/\$8,000 (incl ded) |
| Co-Insurance   | 10%                        |
| Primary Care   | \$15 ded waived            |
| Specialist   | \$35 ded waived            |
| Inpatient Hospital   | 10% after ded              |
| <b>Out-Network</b>   |                            |
|  |                            |
| Ind/Fam Deductible   |                            |
| Ind/Fam OOP Limit  |                            |
| Co-Insurance   |                            |
| Primary Care   |                            |
| Specialist   |                            |
| Inpatient Hospital   |                            |
| <b>Single</b>  | <b>0 x      \$902.16</b>   |
| <b>EE with Spouse</b>  | <b>0 x      \$1,804.32</b> |
| <b>EE with Child(ren)</b>  | <b>0 x      \$1,533.67</b> |
| <b>Family</b>  | <b>0 x      \$2,571.16</b> |
| <b>Monthly Cost</b>  | <b>0          \$0.00</b>   |
| <b>Annual Cost</b>   | <b>            \$0.00</b>  |



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

In-Network Out-Network

|                                   | In-Network   | Out-Network |
|-----------------------------------|--|-------------|
| <b>Prescription Drugs</b>         |  |             |
| Drug Card                         | 15/35/75/100 ded T2-3                                |             |
| <b>Cost Share Information</b>     |  |             |
| Individual/Family Deductible      | \$1,000/\$2,000                                      |             |
| Individual/Family OOP Limit       | \$4,000/\$8,000 (incl ded)                           |             |
| Co-Insurance                      | 10%  |             |
| Lifetime Maximum                  | None   |             |
| <b>Office Visits</b>              |  |             |
| 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  |             |
| <b>Rehabilitation Services</b>    |  |             |
|                                   | \$35 ded waived; 60 visits/contr yr comb<br>PT/OT/ST |             |
| Chiropractic Care                 | \$35 ded waived                                      |             |
| <b>Inpatient Services</b>         |  |             |
| 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                                  |             |
| <b>Outpatient Services</b>        |  |             |
| Outpatient Facility               | Hosp-\$300 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          | \$35 ded waived                                      |             |
| Substance Abuse Outpatient        | Rehab-\$35 ded waived                                |             |
| <b>Emergency Care</b>             |  |             |
| Emergency Room                    | \$400 (waived if admitted) ded waived                |             |
| Ambulance                         | No charge  |             |
| Urgent Care                       | \$75 ded waived                                      |             |
| <b>Recovery/Special Needs</b>     |  |             |
| Home Health Care                  | \$35 ded waived; 40 visits/contr yr                  |             |
| <b>Habilitation services</b>      |  |             |
|                                   | \$35 ded waived; 60 visits/contr yr comb<br>PT/OT/ST |             |
| Skilled Nursing                   | 10% after ded; 200 days/contr yr                     |             |
| Durable Medical Equipment         | 10% after ded  |             |
| Hospice Services                  | 10% after ded IP; \$35 ded waived OP                 |             |
| <b>Miscellaneous Services</b>     |  |             |
| Pediatric Vision Exam             | \$15 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 \$4,000/\$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 \$300 (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



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

In-Network    Out-Network

|                                   | In-Network   | Out-Network |
|-----------------------------------|--|-------------|
| <b>Prescription Drugs</b>         |  |             |
| Drug Card                         | 10/65/50%to\$800                                     |             |
| <b>Cost Share Information</b>     |  |             |
| Individual/Family Deductible      | \$1,250/\$2,500                                      |             |
| Individual/Family OOP Limit       | \$5,500/\$11,000 (incl ded)                          |             |
| Co-Insurance                      | 20%  |             |
| Lifetime Maximum                  | None   |             |
| <b>Office Visits</b>              |  |             |
| 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  |             |
| <b>Rehabilitation Services</b>    |  |             |
|                                   | \$40 ded waived; 60 visits/contr yr comb<br>PT/OT/ST |             |
| <b>Chiropractic Care</b>          |  |             |
|                                   | \$40 ded waived                                      |             |
| <b>Inpatient Services</b>         |  |             |
| Inpatient Hospital                | 20% after ded  |             |
| Inpatient Surgery                 | 20% after ded  |             |
| Maternity Delivery/Inpatient      | 20% after ded  |             |
| <b>Mental Health Inpatient</b>    |  |             |
|                                   | 20% after ded  |             |
| <b>Substance Abuse Inpatient</b>  |  |             |
|                                   | Rehab-20% after ded                                  |             |
| <b>Outpatient Services</b>        |  |             |
| 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                  |             |
| <b>Advanced Radiology</b>         |  |             |
|                                   | \$150 after ded                                      |             |
| <b>Mental Health Outpatient</b>   |  |             |
|                                   | \$40 ded waived                                      |             |
| <b>Substance Abuse Outpatient</b> |  |             |
|                                   | Rehab-\$40 ded waived                                |             |
| <b>Emergency Care</b>             |  |             |
| Emergency Room                    | \$500 (waived if admitted) ded waived                |             |
| Ambulance                         | No charge  |             |
| Urgent Care                       | \$65 ded waived                                      |             |
| <b>Recovery/Special Needs</b>     |  |             |
| Home Health Care                  | \$40 ded waived; 40 visits/contr yr                  |             |
| <b>Habilitation services</b>      |  |             |
|                                   | \$40 ded waived; 60 visits/contr yr comb<br>PT/OT/ST |             |
| <b>Skilled Nursing</b>            |  |             |
|                                   | 20% after ded; 200 days/contr yr                     |             |
| <b>Durable Medical Equipment</b>  |  |             |
|                                   | 20% after ded  |             |
| <b>Hospice Services</b>           |  |             |
|                                   | 20% after ded IP; \$40 ded waived OP                 |             |
| <b>Miscellaneous Services</b>     |  |             |
| Pediatric Vision Exam             | \$25 ded waived                                      |             |
| Pediatric Vision Hardware         | 50% ded waived                                       |             |
| Pediatric Dental Check-Up         | 0% after ded   |             |



Oscar  
 Classic Gold 0 \* (EPO) (UCR=N/A)

|                                   | In-Network                                 | Out-Network |
|-----------------------------------|--|-------------|
| <b>Prescription Drugs</b>         |  |             |
| Drug Card                         | 10/50/100                                  |             |
| <b>Cost Share Information</b>     |  |             |
| Individual/Family Deductible      | N/A  |             |
| Individual/Family OOP Limit       | \$5,000/\$10,000 (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               | \$75                                       |             |
| Outpatient Surgery                | \$75                                       |             |
| Lab/X-Ray                         | Lab-\$25; X-ray-\$50                       |             |
| Advanced Radiology                | \$100                                      |             |
| Mental Health Outpatient          | \$50                                       |             |
| Substance Abuse Outpatient        | \$50                                       |             |
| <b>Emergency Care</b>             |  |             |
| Emergency Room                    | \$500                                      |             |
| Ambulance                         | \$500                                      |             |
| Urgent Care                       | \$75                                       |             |
| <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         | \$100                                      |             |
| Hospice Services                  | \$500/admit IP; \$25 OP; 210 days/yr       |             |
| <b>Miscellaneous Services</b>     |  |             |
| Pediatric Vision Exam             | \$25; 1 exam/12 mo                         |             |
| Pediatric Vision Hardware         | \$100; 1 pair/12 mo                        |             |
| Pediatric Dental Check-Up         | \$100; 1 exam/6 mo                         |             |

The rates and benefits in this report are for discussion and estimation purposes only and are not valid without approval from the insurance carriers. Final rates must be based on insurance carrier confirmation and final enrollment. Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible



| HealthFirst<br>Gold Pro EPO* (EPOc) (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                   | \$5,000/\$10,000 (incl ded)                                |             |
| Co-Insurance                                  | 0%   |             |
| Lifetime Maximum                              | None   |             |
| <b>Office Visits</b>                          |  |             |
| Primary Care                                  | \$25   |             |
| Specialist                                    | \$40   |             |
| Adult Preventive Care                         | No charge  |             |
| Child Preventive Care                         | No charge  |             |
| Maternity Prenatal/Postnatal Care             | No charge  |             |
| Rehabilitation Services                       | \$40; 60 visits/cond/plan yr comb PT/OT/ST                 |             |
| Chiropractic Care                             | \$40   |             |
| <b>Inpatient Services</b>                     |  |             |
| Inpatient Hospital                            | \$500/day; \$1,500 max/admit                               |             |
| Inpatient Surgery                             | \$300  |             |
| Maternity Delivery/Inpatient                  | Delivery-\$100; IP-\$500/day; \$1,500 max/admit            |             |
| Mental Health Inpatient                       | \$500/day; \$1,500 max/admit                               |             |
| Substance Abuse Inpatient                     | \$500/day; \$1,500 max/admit                               |             |
| <b>Outpatient Services</b>                    |  |             |
| Outpatient Facility                           | \$300  |             |
| Outpatient Surgery                            | \$300  |             |
| Lab/X-Ray                                     | PCP-\$25; SP-\$40  |             |
| Advanced Radiology                            | \$40   |             |
| 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                         | \$40; 60 visits/cond/plan yr comb PT/OT/ST                 |             |
| Skilled Nursing                               | \$500/day; \$1,500 max/admit; 200 days/plan yr             |             |
| Durable Medical Equipment                     | 15%  |             |
| Hospice Services                              | \$500/day; \$1,500 max/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  |             |



| Empire EPO/PPO<br>Gold EPO 500/20%/7350* (EPOc) (UCR=N/A) |   |             |
|---|---|-------------|
|   | In-Network                                  | Out-Network |
| <b>Prescription Drugs</b>                                 |   |             |
| Drug Card   | 10/35/75                                    |             |
| <b>Cost Share Information</b>                             |   |             |
| Individual/Family Deductible                              | \$500/\$1,500 embedded                      |             |
| Individual/Family OOP Limit                               | \$7,350/\$14,700 (incl ded)                 |             |
| Co-Insurance  | 20%   |             |
| Lifetime Maximum  | None  |             |
| <b>Office Visits</b>                                      |   |             |
| 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                             |             |
| <b>Inpatient Services</b>                                 |   |             |
| 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                               |             |
| <b>Outpatient Services</b>                                |   |             |
| 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                             |             |
| <b>Emergency Care</b>                                     |   |             |
| Emergency Room  | \$300 ded waived                            |             |
| Ambulance   | 20% after ded                               |             |
| Urgent Care   | \$75 ded waived                             |             |
| <b>Recovery/Special Needs</b>                             |   |             |
| Home Health Care  | 20% after ded; 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                               |             |
| <b>Miscellaneous Services</b>                             |   |             |
| Pediatric Vision Exam                                     | No charge                                   |             |
| Pediatric Vision Hardware                                 | No charge                                   |             |
| Pediatric Dental Check-Up                                 | 0% after ded                                |             |





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

|                                   | In-Network                                       | Out-Network |
|-----------------------------------|--|-------------|
| <b>Prescription Drugs</b>         |  |             |
| Drug Card                         | 10/35/75   |             |
| <b>Cost Share Information</b>     |  |             |
| Individual/Family Deductible      | N/A  |             |
| Individual/Family OOP Limit       | \$5,850/\$11,700                                 |             |
| Co-Insurance                      | 10%  |             |
| Lifetime Maximum                  | None   |             |
| <b>Office Visits</b>              |  |             |
| 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   |             |
| <b>Inpatient Services</b>         |  |             |
| Inpatient Hospital                | \$500/day; 4 days/admit                          |             |
| Inpatient Surgery                 | No charge  |             |
| Maternity Delivery/Inpatient      | \$500/day; 4 days/admit                          |             |
| Mental Health Inpatient           | \$500/day; 4 days/admit                          |             |
| Substance Abuse Inpatient         | \$500/day; 4 days/admit                          |             |
| <b>Outpatient Services</b>        |  |             |
| Outpatient Facility               | \$500  |             |
| Outpatient Surgery                | No charge  |             |
| 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   |             |
| <b>Emergency Care</b>             |  |             |
| Emergency Room                    | \$350  |             |
| Ambulance                         | \$350  |             |
| Urgent Care                       | \$100  |             |
| <b>Recovery/Special Needs</b>     |  |             |
| Home Health Care                  | \$50; 40 visits/yr                               |             |
| Habilitation services             | \$50; 60 visits/yr comb PT/OT/ST                 |             |
| Skilled Nursing                   | \$500/day; 4 days/admit; 200 days/yr             |             |
| Durable Medical Equipment         | 10%  |             |
| Hospice Services                  | 10%  |             |
| <b>Miscellaneous Services</b>     |  |             |
| Pediatric Vision Exam             | No charge  |             |
| Pediatric Vision Hardware         | No charge  |             |
| Pediatric Dental Check-Up         | No charge  |             |



| EmblemHealth<br>EmblemHealth Gold 40/60* (HMOc) (UCR=N/A) |  |             |
|---|--|-------------|
|   | In-Network   | Out-Network |
| <b>Prescription Drugs</b>                                 |  |             |
| Drug Card   | 15/35/75/100 ded   |             |
| <b>Cost Share Information</b>                             |  |             |
| Individual/Family Deductible                              | \$250/\$500  |             |
| Individual/Family OOP Limit                               | \$5,500/\$11,000 (incl ded)  |             |
| Co-Insurance  | 0%   |             |
| Lifetime Maximum  | None   |             |
| <b>Office Visits</b>                                      |  |             |
| 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  |             |
| <b>Rehabilitation Services</b>                            |  |             |
|   | \$60 after ded; 60 visits/cond/plan yr comb<br>PT/OT/ST; pre-auth req            |             |
| Chiropractic Care   | \$60 after ded   |             |
| <b>Inpatient Services</b>                                 |  |             |
| 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;<br>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  |             |
| <b>Outpatient Services</b>                                |  |             |
| Outpatient Facility                                       | \$150 after ded; pre-auth req  |             |
| Outpatient Surgery  | No charge; pre-auth req  |             |
| Lab/X-Ray   | \$60 after ded   |             |
| Advanced Radiology  | \$60 after ded   |             |
| Mental Health Outpatient                                  | \$40 after ded   |             |
| Substance Abuse Outpatient                                | \$40 after ded   |             |
| <b>Emergency Care</b>                                     |  |             |
| Emergency Room  | \$200 (waived if admitted) after ded   |             |
| Ambulance   | \$100 after ded  |             |
| Urgent Care   | \$60 after ded   |             |
| <b>Recovery/Special Needs</b>                             |  |             |
| Home Health Care  | \$40 after ded; 40 visits/plan yr; pre-auth req                                  |             |
| <b>Habilitation services</b>                              |  |             |
|   | \$60 after ded; 60 visits/cond/plan yr comb<br>PT/OT/ST; pre-auth req            |             |
| Skilled Nursing   | \$1,500/admit after ded; 200 days/plan yr;<br>pre-auth req                       |             |
| Durable Medical Equipment                                 | 10% after ded; pre-auth req  |             |
| Hospice Services  | \$1,500/admit after ded IP; \$40 after ded OP;<br>210 days/plan yr; pre-auth req |             |
| <b>Miscellaneous Services</b>                             |  |             |
| 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  |             |



Aetna  
 Gold EPO 1000 90% ID: 14038844\* (EPOc) (UCR=N/A)

|                                   | In-Network                            | Out-Network |
|-----------------------------------|---------------------------------------|-------------|
| <b>Prescription Drugs</b>         |                                       |             |
| Drug Card                         | 15/65/50%/TCS/100 ded T2-4            |             |
| <b>Cost Share Information</b>     |                                       |             |
| Individual/Family Deductible      | \$1,000/\$2,000 embedded              |             |
| Individual/Family OOP Limit       | \$6,000/\$12,000 (incl ded)           |             |
| Co-Insurance                      | 10%                                   |             |
| Lifetime Maximum                  | None                                  |             |
| <b>Office Visits</b>              |                                       |             |
| 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                       |             |
| <b>Inpatient Services</b>         |                                       |             |
| 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                         |             |
| <b>Outpatient Services</b>        |                                       |             |
| 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                       |             |
| <b>Emergency Care</b>             |                                       |             |
| Emergency Room                    | \$750 (waived if admitted) ded waived |             |
| Ambulance                         | 10% after ded                         |             |
| Urgent Care                       | \$75 ded waived                       |             |
| <b>Recovery/Special Needs</b>     |                                       |             |
| 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                         |             |
| <b>Miscellaneous Services</b>     |                                       |             |
| 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             |             |



|                                   | Oxford Metro<br>M Gold EPO 25/40 Gated OHI CNT* (EPOc)<br>(UCR=N/A) |             | Oxford Liberty<br>L Gold EPO 30/60 Gated OHI CNT* (EPOc)<br>(UCR=N/A) |             | Oxford Freedom<br>F Gold EPO 15/35 Non-Gated OHI CNT* (EPOc)<br>(UCR=N/A) |             |
|-----------------------------------|---|-------------|---|-------------|---|-------------|
|                                   | In-Network  | Out-Network | In-Network  | Out-Network | In-Network  | Out-Network |
| <b>Prescription Drugs</b>         |   |             |   |             |   |             |
| Drug Card                         | 10/65/50%to\$800  |             | 15/35/75/100 ded T2-3   |             | 15/35/75/100 ded T2-3   |             |
| <b>Cost Share Information</b>     |   |             |   |             |   |             |
| Individual/Family Deductible      | \$1,250/\$2,500   |             | \$1,000/\$2,000   |             | \$1,000/\$2,000   |             |
| Individual/Family OOP Limit       | \$5,500/\$11,000 (incl ded)   |             | \$4,000/\$8,000 (incl ded)  |             | \$4,000/\$8,000 (incl ded)  |             |
| Co-Insurance                      | 20%   |             | 0%  |             | 10%   |             |
| <b>Office Visits</b>              |   |             |   |             |   |             |
| Primary Care                      | \$25 ded waived   |             | \$30 ded waived   |             | \$15 ded waived   |             |
| Specialist                        | \$40 ded waived   |             | \$60 ded waived   |             | \$35 ded waived   |             |
| Maternity Prenatal/Postnatal Care | No charge   |             | No charge   |             | No charge   |             |
| Chiropractic Care                 | \$40 ded waived   |             | \$60 ded waived   |             | \$35 ded waived   |             |
| <b>Inpatient Services</b>         |   |             |   |             |   |             |
| Inpatient Hospital                | 20% after ded   |             | \$500/day after ded; \$2,000 max/admit                                |             | 10% after ded   |             |
| Mental Health Inpatient           | 20% after ded   |             | \$500/day after ded; \$2,000 max/admit                                |             | 10% after ded   |             |
| Substance Abuse Inpatient         | Rehab-20% after ded   |             | Rehab-\$500/day after ded; \$2,000 max/admit                          |             | Rehab-10% after ded   |             |
| <b>Outpatient Services</b>        |   |             |   |             |   |             |
| Outpatient Facility               | Hosp-\$500 after ded; FS-\$200 after ded                            |             | Hosp-\$250 after ded; FS-\$150 after ded                              |             | Hosp-\$300 after ded; FS-\$150 after ded                                  |             |
| Lab/X-Ray                         | Lab-No charge; X-ray-\$50 after ded                                 |             | Lab-No charge; X-ray-\$35 after ded                                   |             | Lab-No charge; X-ray-\$80 after ded                                       |             |
| Advanced Radiology                | \$150 after ded   |             | \$100 after ded   |             | \$150 after ded   |             |
| Mental Health Outpatient          | \$40 ded waived   |             | \$60 ded waived   |             | \$35 ded waived   |             |
| Substance Abuse Outpatient        | Rehab-\$40 ded waived   |             | Rehab-\$60 ded waived   |             | Rehab-\$35 ded waived   |             |
| <b>Emergency Care</b>             |   |             |   |             |   |             |
| Emergency Room                    | \$500 (waived if admitted) ded waived                               |             | \$300 (waived if admitted) ded waived                                 |             | \$400 (waived if admitted) ded waived                                     |             |
| Ambulance                         | No charge   |             | No charge   |             | No charge   |             |
| Urgent Care                       | \$65 ded waived   |             | \$75 ded waived   |             | \$75 ded waived   |             |
| <b>Recovery/Special Needs</b>     |   |             |   |             |   |             |
| Home Health Care                  | \$40 ded waived; 40 visits/contr yr                                 |             | \$60 ded waived; 40 visits/contr yr                                   |             | \$35 ded waived; 40 visits/contr yr                                       |             |
| Skilled Nursing                   | 20% after ded; 200 days/contr yr                                    |             | \$500/day after ded; \$2,000 max/admit; 200 days/contr yr             |             | 10% after ded; 200 days/contr yr  |             |
| Durable Medical Equipment         | 20% after ded   |             | 0% after ded  |             | 10% after ded   |             |
| Single                            | 0 x \$700.96  |             | 0 x \$843.04  |             | 0 x \$902.16  |             |
| EE with Spouse                    | 0 x \$1,401.92  |             | 0 x \$1,686.08  |             | 0 x \$1,804.32  |             |
| EE with Child(ren)                | 0 x \$1,191.63  |             | 0 x \$1,433.17  |             | 0 x \$1,533.67  |             |
| Family                            | 0 x \$1,997.73  |             | 0 x \$2,402.67  |             | 0 x \$2,571.16  |             |
| Monthly Cost                      | 0 \$0.00  |             | 0 \$0.00  |             | 0 \$0.00  |             |
| Annual Cost                       | \$0.00  |             | \$0.00  |             | \$0.00  |             |

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|                                   | Empire EPO/PPO<br>Gold EPO 500/20%/7350* (EPOc) (UCR=N/A) |             | HealthFirst<br>Gold Pro EPO* (EPOc) (UCR=N/A)  |             | Oscar<br>Classic Gold 0* (EPO) (UCR=N/A) |             |
|-----------------------------------|---|-------------|--|-------------|--|-------------|
|                                   | In-Network  | Out-Network | In-Network                                     | Out-Network | In-Network                               | Out-Network |
| <b>Prescription Drugs</b>         |   |             |  |             |  |             |
| Drug Card                         | 10/35/75  |             | 10/50/85                                       |             | 10/50/100                                |             |
| <b>Cost Share Information</b>     |   |             |  |             |  |             |
| Individual/Family Deductible      | \$500/\$1,500 embedded                                    |             | N/A  |             | N/A                                      |             |
| Individual/Family OOP Limit       | \$7,350/\$14,700 (incl ded)                               |             | \$5,000/\$10,000 (incl ded)                    |             | \$5,000/\$10,000 (incl ded)              |             |
| Co-Insurance                      | 20%   |             | 0%   |             | 0%                                       |             |
| <b>Office Visits</b>              |   |             |  |             |  |             |
| Primary Care                      | \$25 ded waived   |             | \$25   |             | \$25                                     |             |
| Specialist                        | \$50 ded waived   |             | \$40   |             | \$50                                     |             |
| Maternity Prenatal/Postnatal Care | Pre-No charge; Post-20% after ded                         |             | No charge                                      |             | No charge                                |             |
| Chiropractic Care                 | \$50 ded waived   |             | \$40   |             | \$50                                     |             |
| <b>Inpatient Services</b>         |   |             |  |             |  |             |
| Inpatient Hospital                | 20% after ded   |             | \$500/day; \$1,500 max/admit                   |             | \$500/admit                              |             |
| Mental Health Inpatient           | 20% after ded   |             | \$500/day; \$1,500 max/admit                   |             | \$500/admit                              |             |
| Substance Abuse Inpatient         | 20% after ded   |             | \$500/day; \$1,500 max/admit                   |             | \$500/admit                              |             |
| <b>Outpatient Services</b>        |   |             |  |             |  |             |
| Outpatient Facility               | 20% after ded   |             | \$300  |             | \$75                                     |             |
| Lab/X-Ray                         | 20% after ded   |             | PCP-\$25; SP-\$40                              |             | Lab-\$25; X-ray-\$50                     |             |
| Advanced Radiology                | 20% after ded   |             | \$40   |             | \$100                                    |             |
| Mental Health Outpatient          | \$50 ded waived   |             | \$25   |             | \$50                                     |             |
| Substance Abuse Outpatient        | \$50 ded waived   |             | \$25   |             | \$50                                     |             |
| <b>Emergency Care</b>             |   |             |  |             |  |             |
| Emergency Room                    | \$300 ded waived  |             | \$350 (waived if admitted)                     |             | \$500                                    |             |
| Ambulance                         | 20% after ded   |             | \$150  |             | \$500                                    |             |
| Urgent Care                       | \$75 ded waived   |             | \$60   |             | \$75                                     |             |
| <b>Recovery/Special Needs</b>     |   |             |  |             |  |             |
| Home Health Care                  | 20% after ded; 40 visits/yr                               |             | \$25; 40 visits/plan yr                        |             | \$25; 40 visits/plan yr                  |             |
| Skilled Nursing                   | 20% after ded; 200 days/yr                                |             | \$500/day; \$1,500 max/admit; 200 days/plan yr |             | \$500/admit; 200 days/plan yr            |             |
| Durable Medical Equipment         | 20% after ded   |             | 15%  |             | \$100                                    |             |
| Single                            | 0 x \$894.50  |             | 0 x \$728.03                                   |             | 0 x \$731.50                             |             |
| EE with Spouse                    | 0 x \$1,789.00  |             | 0 x \$1,456.06                                 |             | 0 x \$1,463.00                           |             |
| EE with Child(ren)                | 0 x \$1,520.65  |             | 0 x \$1,237.65                                 |             | 0 x \$1,243.55                           |             |
| Family                            | 0 x \$2,549.33  |             | 0 x \$2,074.89                                 |             | 0 x \$2,084.77                           |             |
| Monthly Cost                      | 0 \$0.00  |             | 0 \$0.00                                       |             | 0 \$0.00                                 |             |
| Annual Cost                       | \$0.00  |             | \$0.00   |             | \$0.00                                   |             |

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|                                   | Aetna<br>Gold EPO 1000 90% ID: 14038844* (EPOc)<br>(UCR=N/A) |             | EmblemHealth<br>EmblemHealth Gold 40/60* (HMOc) (UCR=N/A)     |             | Empire Blue Priority<br>Gold Blue Priority EPO 35/10%/5850* (EPOc)<br>(UCR=N/A) |             |
|-----------------------------------|--|-------------|---|-------------|---|-------------|
|                                   | In-Network   | Out-Network | In-Network  | Out-Network | In-Network  | Out-Network |
| <b>Prescription Drugs</b>         |  |             |   |             |   |             |
| Drug Card                         | 15/65/50%/TCS/100 ded<br>T2-4                                |             | 15/35/75/100 ded  |             | 10/35/75  |             |
| <b>Cost Share Information</b>     |  |             |   |             |   |             |
| Individual/Family Deductible      | \$1,000/\$2,000 embedded                                     |             | \$250/\$500   |             | N/A   |             |
| Individual/Family OOP Limit       | \$6,000/\$12,000 (incl ded)                                  |             | \$5,500/\$11,000 (incl ded)                                   |             | \$5,850/\$11,700  |             |
| Co-Insurance                      | 10%  |             | 0%  |             | 10%   |             |
| <b>Office Visits</b>              |  |             |   |             |   |             |
| Primary Care                      | \$30 ded waived  |             | \$40 after ded  |             | \$35  |             |
| Specialist                        | \$60 ded waived  |             | \$60 after ded  |             | \$50  |             |
| Maternity Prenatal/Postnatal Care | Pre-No charge; Post-refer to carrier                         |             | No charge   |             | No charge   |             |
| Chiropractic Care                 | \$60 ded waived  |             | \$60 after ded  |             | \$50  |             |
| <b>Inpatient Services</b>         |  |             |   |             |   |             |
| Inpatient Hospital                | 10% after ded  |             | \$1,500/admit after ded;<br>pre-auth req                      |             | \$500/day; 4 days/admit   |             |
| Mental Health Inpatient           | 10% after ded  |             | \$1,500/admit after ded;<br>pre-auth req                      |             | \$500/day; 4 days/admit   |             |
| Substance Abuse Inpatient         | 10% after ded  |             | \$1,500/admit after ded;<br>pre-auth req                      |             | \$500/day; 4 days/admit   |             |
| <b>Outpatient Services</b>        |  |             |   |             |   |             |
| Outpatient Facility               | Refer to Outpatient Surgery                                  |             | \$150 after ded; pre-auth req                                 |             | \$500   |             |
| Lab/X-Ray                         | 10% after ded  |             | \$60 after ded  |             | Lab-No charge; X-ray:<br>Office-No charge; OP-<br>\$100                         |             |
| Advanced Radiology                | 10% after ded  |             | \$60 after ded  |             | Office-\$50; OP-\$200   |             |
| Mental Health Outpatient          | \$60 ded waived  |             | \$40 after ded  |             | \$50  |             |
| Substance Abuse Outpatient        | \$60 ded waived  |             | \$40 after ded  |             | \$50  |             |
| <b>Emergency Care</b>             |  |             |   |             |   |             |
| Emergency Room                    | \$750 (waived if admitted)<br>ded waived                     |             | \$200 (waived if admitted)<br>after ded                       |             | \$350   |             |
| Ambulance                         | 10% after ded  |             | \$100 after ded   |             | \$350   |             |
| Urgent Care                       | \$75 ded waived  |             | \$60 after ded  |             | \$100   |             |
| <b>Recovery/Special Needs</b>     |  |             |   |             |   |             |
| Home Health Care                  | 25% ded waived; 40<br>visits/cal yr                          |             | \$40 after ded; 40<br>visits/plan yr; pre-auth req            |             | \$50; 40 visits/yr  |             |
| Skilled Nursing                   | 10% after ded  |             | \$1,500/admit after ded;<br>200 days/plan yr; pre-auth<br>req |             | \$500/day; 4 days/admit;<br>200 days/yr   |             |
| Durable Medical Equipment         | 50% after ded  |             | 10% after ded; pre-auth<br>req                                |             | 10%   |             |
| Single                            | 0 x \$905.99   |             | 0 x \$852.74  |             | 0 x \$854.95  |             |
| EE with Spouse                    | 0 x \$1,811.98   |             | 0 x \$1,705.49  |             | 0 x \$1,709.90  |             |
| EE with Child(ren)                | 0 x \$1,540.18   |             | 0 x \$1,449.67  |             | 0 x \$1,453.42  |             |
| Family                            | 0 x \$2,582.07   |             | 0 x \$2,430.31  |             | 0 x \$2,436.61  |             |
| Monthly Cost                      | 0 \$0.00   |             | 0 \$0.00  |             | 0 \$0.00  |             |
| Annual Cost                       | \$0.00   |             | \$0.00  |             | \$0.00  |             |

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