



	Aetna Gold EPO 1000 90% ID: 14038844 (EPOc) (UCR=N/A)	EmblemHealth EmblemHealth Gold 40/60 (HMOc) (UCR=N/A)	Empire Blue Priority Gold Blue Priority EPO 35/10%/5850 (EPOc) (UCR=N/A)	Empire EPO/PPO Gold EPO 25/0%/6000 (EPO) (UCR=N/A)	HealthFirst Gold Pro EPO (EPOc) (UCR=N/A)	Oscar Classic Gold 0 (EPO) (UCR=N/A)	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)
<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	N/A	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	\$6,000/\$12,000	\$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%	0%	0%	0%	20%	0%
Primary Care	\$30 ded waived	\$40 after ded	\$35	\$25	\$25	\$25	\$25 ded waived	\$30 ded waived
Specialist	\$60 ded waived	\$60 after ded	\$50	\$50	\$40	\$50	\$40 ded waived	\$60 ded waived
Inpatient Hospital	10% after ded	\$1,500/admit after ded; pre-auth req	\$500/day; 4 days/admit	\$350/day; 4 days max/admit	\$500/day; \$1,500 max/admit	\$500/admit	20% after ded	\$500/day after ded; \$2,000 max/admit
<b>Out-Network</b>								
Ind/Fam Deductible								
Ind/Fam OOP Limit								
Co-Insurance								
Primary Care								
Specialist								
Inpatient Hospital								
<b>Single</b>	<b>\$934.56</b>	<b>\$864.68</b>	<b>\$874.18</b>	<b>\$962.60</b>	<b>\$738.95</b>	<b>\$746.13</b>	<b>\$717.10</b>	<b>\$862.45</b>
<b>EE with Spouse</b>	<b>\$1,869.13</b>	<b>\$1,729.37</b>	<b>\$1,748.36</b>	<b>\$1,925.20</b>	<b>\$1,477.90</b>	<b>\$1,492.26</b>	<b>\$1,434.20</b>	<b>\$1,724.91</b>
<b>EE with Child(ren)</b>	<b>\$1,588.76</b>	<b>\$1,469.97</b>	<b>\$1,486.11</b>	<b>\$1,636.42</b>	<b>\$1,256.22</b>	<b>\$1,268.42</b>	<b>\$1,219.07</b>	<b>\$1,466.17</b>
<b>Family</b>	<b>\$2,663.51</b>	<b>\$2,464.33</b>	<b>\$2,491.41</b>	<b>\$2,743.41</b>	<b>\$2,106.01</b>	<b>\$2,126.47</b>	<b>\$2,043.73</b>	<b>\$2,457.99</b>
<b>Monthly Cost</b>								
<b>Annual Cost</b>								



Oxford Freedom F Gold EPO 15/35 Non-Gated OHI CNT (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>\$922.93</b>
<b>EE with Spouse</b>	<b>\$1,845.87</b>
<b>EE with Child(ren)</b>	<b>\$1,568.99</b>
<b>Family</b>	<b>\$2,630.36</b>
<b>Monthly Cost</b>	
<b>Annual Cost</b>	



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	





EmblemHealth  
 EmblemHealth Gold 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; 60 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 \$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; 60 visits/cond/plan yr comb  
 PT/OT/ST; pre-auth req

Skilled Nursing \$1,500/admit after ded; 200 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



Empire Blue Priority  
 Gold Blue Priority EPO 35/10%/5850 (EPOs) (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	

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/Specially/Deductible



Empire EPO/PPO  
 Gold EPO 25/0%/6000 (EPO) (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	\$6,000/\$12,000	
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	
<b>Rehabilitation Services</b>		
	\$50; 60 visits/yr comb PT/OT/ST	
<b>Chiropractic Care</b>		
	\$50	
<b>Inpatient Services</b>		
Inpatient Hospital	\$350/day; 4 days max/admit	
Inpatient Surgery	No charge	
Maternity Delivery/Inpatient	\$350/day; 4 days max/admit	
<b>Mental Health Inpatient</b>		
Substance Abuse Inpatient	\$350/day; 4 days max/admit	
<b>Outpatient Services</b>		
Outpatient Facility	\$300	
Outpatient Surgery	No charge	
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	
<b>Emergency Care</b>		
Emergency Room	\$300	
Ambulance	\$300	
Urgent Care	\$75	
<b>Recovery/Special Needs</b>		
Home Health Care	\$50; 40 visits/yr	
<b>Habilitation services</b>		
	\$50; 60 visits/yr comb PT/OT/ST	
<b>Skilled Nursing</b>		
	\$350/day; 4 days max/admit; 200 days/yr	
<b>Durable Medical Equipment</b>		
Hospice Services	No charge	
<b>Miscellaneous Services</b>		
Pediatric Vision Exam	No charge	
Pediatric Vision Hardware	No charge	
Pediatric Dental Check-Up	No charge	





HealthFirst  
 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	



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	





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

	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 PT/OT/ST	
Chiropractic Care	\$40 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	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	
Advanced Radiology	\$150 after ded	
Mental Health Outpatient	\$40 ded waived	
Substance Abuse Outpatient	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 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	
<b>Miscellaneous Services</b>		
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
<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	0%	
Lifetime Maximum	None	
<b>Office Visits</b>		
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	
<b>Rehabilitation Services</b>		
	\$60 ded waived; 60 visits/contr yr comb PT/OT/ST	
Chiropractic Care	\$60 ded waived	
<b>Inpatient Services</b>		
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	
<b>Outpatient Services</b>		
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	
<b>Emergency Care</b>		
Emergency Room	\$300 (waived if admitted) ded waived	
Ambulance	No charge	
Urgent Care	\$75 ded waived	
<b>Recovery/Special Needs</b>		
Home Health Care	\$60 ded waived; 40 visits/contr yr	
<b>Habilitation services</b>		
	\$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	
<b>Miscellaneous Services</b>		
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
<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 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 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	