



	Aetna Gold OAEPO 1000 90% ID: 14041846* (EPOc) (UCR=N/A)	EmblemHealth EH Gold Premier NG Prime* (HMOc) (UCR=N/A)	EmblemHealth EH Gold Choice NG Select Care* (HMOc) (UCR=N/A)	Empire Blue Access Gold Blue Access EPO 35/10%/5850* (EPOc) (UCR=N/A)	Empire EPO/PPO Gold EPO 25/0%/6000* (EPO) (UCR=N/A)	HealthFirst Gold 25/50/0 Pro EPO* (EPO) (UCR=N/A)	Oscar Circle Circle Gold \$0* (EPOc) (UCR=N/A)	Oscar Circle Plus Circle Plus Gold \$0* (EPOc) (UCR=N/A)
Prescription Drugs								
Drug Card	15/65/50%/TCS/100 ded T2-4	10/30/70	20/45/75 IntDed T2-3	10/50/75	10/50/75	10/50/85	10/25/100	10/25/100
In-Network								
Ind/Fam Deductible	\$1,000/\$2,000 embedded	\$450/\$900	\$750/\$1,500	N/A	N/A	N/A	N/A	N/A
Ind/Fam OOP Limit	\$6,000/\$12,000 (incl ded)	\$4,000/\$8,000 (incl ded)	\$5,000/\$10,000 (incl ded)	\$5,850/\$11,700	\$6,000/\$12,000	\$7,000/\$14,000 (incl ded)	\$5,000/\$10,000	\$5,000/\$10,000
Co-Insurance	10%	0%	0%	10%	0%	0%	20%	20%
Primary Care	\$30 ded waived	No charge visits 1-3; \$30 ded waived visits 4+	No charge visits 1-3; \$30 ded waived visits 4+	\$35	\$25	\$25	\$25	\$25
Specialist	\$60 ded waived	\$50 ded waived	\$50 ded waived	\$50	\$50	\$50	\$50	\$50
Inpatient Hospital	10% after ded	\$1,000/admit after ded	\$2,000/admit after ded	\$500/day; 4 days/admit	\$400/day; 4 days max/admit	\$500/admit	\$500/day; 5 days/admit	\$500/day; 5 days/admit
Out-Network								
Ind/Fam Deductible								
Ind/Fam OOP Limit								
Co-Insurance								
Primary Care								
Specialist								
Inpatient Hospital								
Single	0 x \$1,008.74	0 x \$918.78	0 x \$782.09	0 x \$897.09	0 x \$976.86	0 x \$744.15	0 x \$734.02	0 x \$819.18
EE with Spouse	0 x \$2,017.49	0 x \$1,837.55	0 x \$1,564.17	0 x \$1,794.18	0 x \$1,953.72	0 x \$1,488.30	0 x \$1,468.05	0 x \$1,638.37
EE with Child(ren)	0 x \$1,714.86	0 x \$1,561.92	0 x \$1,329.55	0 x \$1,525.05	0 x \$1,660.66	0 x \$1,265.06	0 x \$1,247.84	0 x \$1,392.61
Family	0 x \$2,874.92	0 x \$2,618.51	0 x \$2,228.94	0 x \$2,556.71	0 x \$2,784.05	0 x \$2,120.83	0 x \$2,091.97	0 x \$2,334.67
Monthly Cost	0 \$0.00	0 \$0.00	0 \$0.00	0 \$0.00	0 \$0.00	0 \$0.00	0 \$0.00	0 \$0.00
Annual Cost	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00



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2019 SMALL GROUP HEALTH INSURANCE RATES

2Q - NYC - For New Groups Starting Second Quarter 2019

	Oxford Metro M Gold EPO 25/40 Gated OHI CNT* (EPOc) (UCR=N/A)	Oxford Liberty L Gold EPO 30/60 Gated OHI CNT* (EPOc) (UCR=N/A)	Oxford Freedom F Gold EPO 15/35 Non-Gated OHI CNT* (EPOc) (UCR=N/A)
Prescription Drugs			
Drug Card	10/65/90/100 ded T2-3	15/35/75/100 ded T2-3	15/35/75/100 ded T2-3
In-Network			
Ind/Fam Deductible	\$1,250/\$2,500	\$1,000/\$2,000	\$1,000/\$2,000
Ind/Fam OOP Limit	\$5,500/\$11,000 (incl ded)	\$4,500/\$9,000 (incl ded)	\$5,250/\$10,500 (incl ded)
Co-Insurance	20%	0%	10%
Primary Care	\$25 ded waived	\$30 ded waived	\$15 ded waived
Specialist	\$40 ded waived	\$60 ded waived	\$35 ded waived
Inpatient Hospital	20% after ded	\$500/day after ded; \$2,000 max/admit	10% after ded
Out-Network			
Ind/Fam Deductible			
Ind/Fam OOP Limit			
Co-Insurance			
Primary Care			
Specialist			
Inpatient Hospital			
Single	0 x \$705.49	0 x \$840.72	0 x \$936.72
EE with Spouse	0 x \$1,410.98	0 x \$1,681.45	0 x \$1,873.44
EE with Child(ren)	0 x \$1,199.33	0 x \$1,429.24	0 x \$1,592.43
Family	0 x \$2,010.64	0 x \$2,396.07	0 x \$2,669.65
Monthly Cost	0 \$0.00	0 \$0.00	0 \$0.00
Annual Cost	 \$0.00	 \$0.00	 \$0.00



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

In-Network

Out-Network

Prescription Drugs

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

Cost Share Information

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

Office Visits

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

Rehabilitation Services \$60 ded waived; visit limits apply

Chiropractic Care \$60 ded waived

Inpatient Services

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

Outpatient Services

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

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

Emergency Care

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

Recovery/Special Needs

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

Skilled Nursing 10% after ded

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

Miscellaneous Services

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



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



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



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

In-Network

Out-Network

Prescription Drugs

Drug Card 10/50/75

Cost Share Information

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

Office Visits

Primary Care \$35
 Specialist \$50
 Adult Preventive Care No charge
 Child Preventive Care No charge
 Maternity Prenatal/Postnatal Care No charge

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

Chiropractic Care \$50

Inpatient Services

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

Outpatient Services

Outpatient Facility \$500
 Outpatient Surgery No charge (physician's charges)
 Lab/X-Ray Lab-No charge; X-ray: Office-No charge; OP-\$100
 Advanced Radiology Office-\$50; OP-\$200
 Mental Health Outpatient \$50
 Substance Abuse Outpatient \$50

Emergency Care

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

Recovery/Special Needs

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

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

Durable Medical Equipment 10%
 Hospice Services 10%

Miscellaneous Services

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



Empire EPO/PPO Gold EPO 25/0%/6000* (EPO) (UCR=N/A)		
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/50/75	
Cost Share Information		
Individual/Family Deductible	N/A	
Individual/Family OOP Limit	\$6,000/\$12,000	
Co-Insurance	0%	
Lifetime Maximum	None	
Office Visits		
Primary Care	\$25	
Specialist	\$50	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	\$50; 60 visits/yr comb PT/OT/ST	
Chiropractic Care	\$50	
Inpatient Services		
Inpatient Hospital	\$400/day; 4 days max/admit	
Inpatient Surgery	No charge (physician's charges)	
Maternity Delivery/Inpatient	\$400/day; 4 days max/admit	
Mental Health Inpatient	\$400/day; 4 days max/admit	
Substance Abuse Inpatient	\$400/day; 4 days max/admit	
Outpatient Services		
Outpatient Facility	\$400	
Outpatient Surgery	No charge (physician's charges)	
Lab/X-Ray	Lab-No charge; X-ray: Office-No charge; OP-\$50	
Advanced Radiology	Office-\$50; OP-\$150	
Mental Health Outpatient	\$50	
Substance Abuse Outpatient	\$50	
Emergency Care		
Emergency Room	\$400	
Ambulance	\$400	
Urgent Care	\$75	
Recovery/Special Needs		
Home Health Care	\$50; 40 visits/yr	
Habilitation services	\$50; 60 visits/yr comb PT/OT/ST	
Skilled Nursing	\$400/day; 4 days max/admit	
Durable Medical Equipment	No charge	
Hospice Services	No charge	
Miscellaneous Services		
Pediatric Vision Exam	No charge	
Pediatric Vision Hardware	No charge	
Pediatric Dental Check-Up	No charge	



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



Oscar Circle Circle Gold \$0* (EPOc) (UCR=N/A)		
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/25/100	
Cost Share Information		
Individual/Family Deductible	N/A	
Individual/Family OOP Limit	\$5,000/\$10,000	
Co-Insurance	20%	
Lifetime Maximum	None	
Office Visits		
Primary Care	\$25	
Specialist	\$50	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	\$25; 60 visits/cond/plan yr comb PT/OT/ST	
Chiropractic Care	\$25	
Inpatient Services		
Inpatient Hospital	\$500/day; 5 days/admit	
Inpatient Surgery	\$150	
Maternity Delivery/Inpatient	\$500/day; 5 days/admit	
Mental Health Inpatient	\$500/day; 5 days/admit	
Substance Abuse Inpatient	\$500/day; 5 days/admit	
Outpatient Services		
Outpatient Facility	\$150	
Outpatient Surgery	\$150	
Lab/X-Ray	\$50	
Advanced Radiology	\$125	
Mental Health Outpatient	\$25	
Substance Abuse Outpatient	\$25	
Emergency Care		
Emergency Room	\$750	
Ambulance	\$750	
Urgent Care	\$75	
Recovery/Special Needs		
Home Health Care	\$50; 40 visits/plan yr	
Habilitation services	\$25; 60 visits/cond/plan yr comb PT/OT/ST	
Skilled Nursing	\$500/day; 5 days/admit; 200 days/plan yr	
Durable Medical Equipment	20%	
Hospice Services	20%; 210 days/plan yr	
Miscellaneous Services		
Pediatric Vision Exam	\$50; 1 exam/12 mo	
Pediatric Vision Hardware	20%; 1 pair/12 mo	
Pediatric Dental Check-Up	No charge; 1 exam/6 mo	



Oscar Circle Plus Circle Plus Gold \$0* (EPOc) (UCR=N/A)		
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/25/100	
Cost Share Information		
Individual/Family Deductible	N/A	
Individual/Family OOP Limit	\$5,000/\$10,000	
Co-Insurance	20%	
Lifetime Maximum	None	
Office Visits		
Primary Care	\$25	
Specialist	\$50	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	\$25; 60 visits/cond/plan yr comb PT/OT/ST	
Chiropractic Care	\$25	
Inpatient Services		
Inpatient Hospital	\$500/day; 5 days/admit	
Inpatient Surgery	\$150	
Maternity Delivery/Inpatient	\$500/day; 5 days/admit	
Mental Health Inpatient	\$500/day; 5 days/admit	
Substance Abuse Inpatient	\$500/day; 5 days/admit	
Outpatient Services		
Outpatient Facility	\$150	
Outpatient Surgery	\$150	
Lab/X-Ray	\$50	
Advanced Radiology	\$125	
Mental Health Outpatient	\$25	
Substance Abuse Outpatient	\$25	
Emergency Care		
Emergency Room	\$750	
Ambulance	\$750	
Urgent Care	\$75	
Recovery/Special Needs		
Home Health Care	\$50; 40 visits/plan yr	
Habilitation services	\$25; 60 visits/cond/plan yr comb PT/OT/ST	
Skilled Nursing	\$500/day; 5 days/admit; 200 days/plan yr	
Durable Medical Equipment	20%	
Hospice Services	20%; 210 days/plan yr	
Miscellaneous Services		
Pediatric Vision Exam	\$50; 1 exam/12 mo	
Pediatric Vision Hardware	20%; 1 pair/12 mo	
Pediatric Dental Check-Up	No charge; 1 exam/6 mo	



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

In-Network

Out-Network

Prescription Drugs

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

Cost Share Information

Individual/Family Deductible \$1,250/\$2,500
 Individual/Family OOP Limit \$5,500/\$11,000 (incl ded)
 Co-Insurance 20%
 Lifetime Maximum None

Office Visits

Primary Care \$25 ded waived
 Specialist \$40 ded waived
 Adult Preventive Care No charge
 Child Preventive Care No charge
 Maternity Prenatal/Postnatal Care No charge

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

Chiropractic Care \$40 ded waived

Inpatient Services

Inpatient Hospital 20% after ded
 Inpatient Surgery 20% after ded
 Maternity Delivery/Inpatient 20% after ded
 Mental Health Inpatient 20% after ded
 Substance Abuse Inpatient Rehab-20% after ded

Outpatient Services

Outpatient Facility Hosp-\$500 after ded; FS-\$200 after ded
 Outpatient Surgery 20% after ded
 Lab/X-Ray Lab-\$15 ded waived; X-ray-\$50 after ded

Advanced Radiology \$150 after ded
 Mental Health Outpatient \$40 ded waived
 Substance Abuse Outpatient Rehab-\$40 ded waived

Emergency Care

Emergency Room \$500 (waived if admitted) ded waived
 Ambulance No charge
 Urgent Care \$65 ded waived

Recovery/Special Needs

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

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

Durable Medical Equipment 20% after ded
 Hospice Services 20% after ded

Miscellaneous Services

Pediatric Vision Exam \$25 ded waived
 Pediatric Vision Hardware 50% ded waived
 Pediatric Dental Check-Up 0% after ded



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

In-Network

Out-Network

Prescription Drugs

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

Cost Share Information

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

Office Visits

Primary Care \$30 ded waived

Specialist \$60 ded waived

Adult Preventive Care No charge

Child Preventive Care No charge

Maternity Prenatal/Postnatal Care No charge

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

Chiropractic Care \$60 ded waived

Inpatient Services

Inpatient Hospital \$500/day after ded; \$2,000 max/admit

Inpatient Surgery 0% after ded

Maternity Delivery/Inpatient \$500/day after ded; \$2,000 max/admit

Mental Health Inpatient \$500/day after ded; \$2,000 max/admit

Substance Abuse Inpatient Rehab-\$500/day after ded; \$2,000 max/admit

Outpatient Services

Outpatient Facility Hosp-\$250 after ded; FS-\$150 after ded

Outpatient Surgery Included in Outpatient Facility

Lab/X-Ray Lab-No charge; X-ray-\$35 after ded

Advanced Radiology \$100 after ded

Mental Health Outpatient \$60 ded waived

Substance Abuse Outpatient Rehab-\$60 ded waived

Emergency Care

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

Ambulance No charge

Urgent Care \$75 ded waived

Recovery/Special Needs

Home Health Care \$60 ded waived; 40 visits/cal yr

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

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

Durable Medical Equipment 0% after ded

Hospice Services \$500/day after ded; \$2,000 max/admit

Miscellaneous Services

Pediatric Vision Exam \$30 ded waived

Pediatric Vision Hardware 50% ded waived

Pediatric Dental Check-Up 0% after ded



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

In-Network

Out-Network

Prescription Drugs

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

Cost Share Information

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

Office Visits

Primary Care \$15 ded waived

Specialist \$35 ded waived

Adult Preventive Care No charge

Child Preventive Care No charge

Maternity Prenatal/Postnatal Care No charge

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

Chiropractic Care \$35 ded waived

Inpatient Services

Inpatient Hospital 10% after ded
 Inpatient Surgery 10% after ded
 Maternity Delivery/Inpatient 10% after ded
 Mental Health Inpatient 10% after ded
 Substance Abuse Inpatient Rehab-10% after ded

Outpatient Services

Outpatient Facility Hosp-\$300 after ded; FS-\$150 after ded
 Outpatient Surgery 10% after ded
 Lab/X-Ray Lab-No charge; X-ray-\$80 after ded

Advanced Radiology \$150 after ded
 Mental Health Outpatient \$35 ded waived
 Substance Abuse Outpatient Rehab-\$35 ded waived

Emergency Care

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

Recovery/Special Needs

Home Health Care \$35 ded waived; 40 visits/cal yr
 Habilitation services \$35 ded waived; 60 visits/cal yr comb PT/OT/ST

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

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

Miscellaneous Services

Pediatric Vision Exam \$15 ded waived
 Pediatric Vision Hardware 50% ded waived
 Pediatric Dental Check-Up 0% after ded