2018 Summary of Benefits

	healthfirst Platinum Pro EPO	oscar Classic Platinum EPO 2K	oscar Classic Platinum EPO 3K
	In-Network	**In-Network**	**In-Network**
Prescription Drugs			
Drug Card	10/30/60	10/30/75	10/30/75
Cost Share Information			
Individual/Family Deductible	N/A	N/A	N/A
Individual/Family OOP Limit	$2,000/$4,000	$2,000/$4,000	$3,000/$6,000
Co-Insurance	0%	0%	0%
Office Visits			
Primary Care	$20	$10	$10
Specialist	$35	$25	$25
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	$35	$25	$25
Inpatient Services			
Inpatient Hospital	$500/admit	$500/admit	$500/admit
Mental Health Inpatient	$500/admit	$500/admit	$500/admit
Substance Abuse Inpatient	$500/admit	$500/admit	$500/admit
Outpatient Services			
Outpatient Facility	$200	$50	$50
Lab/X-Ray	PCP-$20; SP-$35	Lab-$10; X-ray-$50	Lab-$10; X-ray-$50
Advanced Radiology	$35	$100	$100
Mental Health Outpatient	$20	$25	$25
Substance Abuse Outpatient	$20	$25	$25
Emergency Care			
Emergency Room	$250 (waived if admitted)	$200	$200
Ambulance	$150	$200	$200
Urgent Care	$50	$50	$50
Recovery/Special Needs			
Home Health Care	$20; 40 visits/plan yr	$10; 40 visits/plan yr	$10; 40 visits/plan yr
Skilled Nursing	$500/admit; 200 days/plan yr	$500/admit; 200 days/plan yr	$500/admit; 200 days/plan yr
Durable Medical Equipment	10%	$50	$50

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

****Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.**

2018 Summary of Benefits

	UnitedHealthcare OXFORD **Liberty Advantage Platinum EPO 15/35****	healthfirst Health Insurance for New Yorkers **Gold Pro EPO**	oscar **Classic Gold EPO**
	In-Network	**In-Network**	**In-Network**
Prescription Drugs			
Drug Card	5/30/60/150 ded T2-3	10/50/85	10/50/100
Cost Share Information			
Individual/Family Deductible	$250/$500	N/A	N/A
Individual/Family OOP Limit	$3,000/$6,000 (incl ded)	$5,000/$10,000 (incl ded)	$5,000/$10,000 (incl ded)
Co-Insurance	10%	0%	0%
Office Visits			
Primary Care	$15 ded waived	$25	$25
Specialist	$35 ded waived	$40	$50
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	$35 ded waived	$40	$50
Inpatient Services			
Inpatient Hospital	10% after ded	$500/day; $1,500 max/admit	$500/admit
Mental Health Inpatient	10% after ded	$500/day; $1,500 max/admit	$500/admit
Substance Abuse Inpatient	Rehab-10% after ded	$500/day; $1,500 max/admit	$500/admit
Outpatient Services			
Outpatient Facility	10% after ded	$300	$75
Lab/X-Ray	10% after ded	PCP-$25; SP-$40	Lab-$25; X-ray-$50
Advanced Radiology	10% after ded	$40	$100
Mental Health Outpatient	$35 ded waived	$25	$50
Substance Abuse Outpatient	Rehab-$35 ded waived	$25	$50
Emergency Care			
Emergency Room	10% after ded	$350 (waived if admitted)	$500
Ambulance	No charge	$150	$500
Urgent Care	$50 ded waived	$60	$75
Recovery/Special Needs			
Home Health Care	$35 ded waived; 40 visits/contr yr	$25; 40 visits/plan yr	$25; 40 visits/plan yr
Skilled Nursing	10% after ded; 200 days/contr yr	$500/day; $1,500 max/admit; 200 days/plan yr	$500/admit; 200 days/plan yr
Durable Medical Equipment	10% after ded	15%	$100

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

****Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.**

2018 Summary of Benefits

	Classic Gold EPO 1K	Simple Gold EPO	Liberty Gold EPO 30/60**
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	10/50/100	10/50/0% IntDed T3	15/35/75/100 ded T2-3
Cost Share Information			
Individual/Family Deductible	$1,000/$2,000	$4,000/$8,000	$1,000/$2,000
Individual/Family OOP Limit	$5,000/$10,000 (incl ded)	$4,000/$8,000 (incl ded)	$4,000/$8,000 (incl ded)
Co-Insurance	20%	0%	0%
Office Visits			
Primary Care	$25 ded waived	$10 ded waived	$30 ded waived
Specialist	$50 ded waived	$50 ded waived	$60 ded waived
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	$50 ded waived	$50 ded waived	$60 ded waived
Inpatient Services			
Inpatient Hospital	20% after ded	0% after ded	$500/day after ded; $2,000 max/admit
Mental Health Inpatient	20% after ded	0% after ded	$500/day after ded; $2,000 max/admit
Substance Abuse Inpatient	20% after ded	0% after ded	Rehab-$500/day after ded; $2,000 max/admit
Outpatient Services			
Outpatient Facility	20% after ded	$100 ded waived	Hosp-$250 after ded; FS- $150 after ded
Lab/X-Ray	Lab-$25 ded waived; X-ray-20% after ded	Lab-$25 ded waived; X-ray-0% after ded	Lab-No charge; X-ray- $35 after ded
Advanced Radiology	20% after ded	0% after ded	$100 after ded
Mental Health Outpatient	$50 ded waived	$50 ded waived	$60 ded waived
Substance Abuse Outpatient	$50 ded waived	$50 ded waived	Rehab-$60 ded waived
Emergency Care			
Emergency Room	$500 ded waived	0% after ded	$300 (waived if admitted) ded waived
Ambulance	$500 ded waived	0% after ded	No charge
Urgent Care	$75 ded waived	$100 ded waived	$75 ded waived
Recovery/Special Needs			
Home Health Care	$25 ded waived; 40 visits/plan yr	$50 ded waived; 40 visits/plan yr	$60 ded waived; 40 visits/contr yr
Skilled Nursing	20% after ded; 200 days/plan yr	0% after ded; 200 days/plan yr	$500/day after ded; $2,000 max/admit; 200 days/contr yr
Durable Medical Equipment	20% after ded	0% after ded	0% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

****Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.**

2018 Summary of Benefits

	UnitedHealthcare OXFORD **Liberty Advantage Gold EPO 25/45****	UnitedHealthcare OXFORD **Metro Gold EPO 25/40 NG**	UnitedHealthcare OXFORD **Oxford Metro Gold EPO 25/40****
	In-Network	**In-Network**	**In-Network**
Prescription Drugs			
Drug Card	5/45/75/150 ded T2-3	10/65/90/100 ded T2-3	10/65/50%to$800
Cost Share Information			
Individual/Family Deductible	$1,500/$3,000	$1,250/$2,500	$1,250/$2,500
Individual/Family OOP Limit	$6,000/$12,000 (incl ded)	$5,000/$10,000 (incl ded)	$5,500/$11,000 (incl ded)
Co-Insurance	20%	20%	20%
Office Visits			
Primary Care	$25 ded waived	$25 ded waived	$25 ded waived
Specialist	$45 ded waived	$40 ded waived	$40 ded waived
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	$45 ded waived	$40 ded waived	$40 ded waived
Inpatient Services			
Inpatient Hospital	20% after ded	20% after ded	20% after ded
Mental Health Inpatient	20% after ded	20% after ded	20% after ded
Substance Abuse Inpatient	Rehab-20% after ded	Rehab-20% after ded	Rehab-20% after ded
Outpatient Services			
Outpatient Facility	20% after ded	Hosp-$500 after ded; FS- $200 after ded	Hosp-$500 after ded; FS- $200 after ded
Lab/X-Ray	20% after ded	Lab-No charge; X-ray- $50 after ded	Lab-No charge; X-ray- $50 after ded
Advanced Radiology	20% after ded	$150 after ded	$150 after ded
Mental Health Outpatient	$45 ded waived	$40 ded waived	$40 ded waived
Substance Abuse Outpatient	Rehab-$45 ded waived	Rehab-$40 ded waived	Rehab-$40 ded waived
Emergency Care			
Emergency Room	20% after ded	$400 (waived if admitted) ded waived	$500 (waived if admitted) ded waived
Ambulance	No charge	No charge	No charge
Urgent Care	$75 ded waived	$65 ded waived	$65 ded waived
Recovery/Special Needs			
Home Health Care	$45 ded waived; 40 visits/contr yr	$40 ded waived; 40 visits/contr yr	$40 ded waived; 40 visits/contr yr
Skilled Nursing	20% after ded; 200 days/contr yr	20% after ded; 200 days/contr yr	20% after ded; 200 days/contr yr
Durable Medical Equipment	20% after ded	20% after ded	20% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

****Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.**

2018 Summary of Benefits

	healthfirst Health Insurance for New Yorkers **Silver Pro EPO**	oscar **Classic Silver EPO 3K**	oscar **Classic Silver EPO 4.5K**
	In-Network	**In-Network**	**In-Network**
Prescription Drugs			
Drug Card	20/60/110	20/50/100	10/50%/50% IntDed T2-3
Cost Share Information			
Individual/Family Deductible	$2,600/$5,200	$3,000/$6,000	$4,500/$9,000
Individual/Family OOP Limit	$7,300/$14,600 (incl ded)	$7,350/$14,700 (incl ded)	$7,350/$14,700 (incl ded)
Co-Insurance	30%	30%	50%
Office Visits			
Primary Care	$35 ded waived	$25 ded waived	$25 ded waived
Specialist	$70 ded waived	$75 ded waived	$75 ded waived
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	$70 ded waived	$75 ded waived	$75 ded waived
Inpatient Services			
Inpatient Hospital	30% after ded	30% after ded	50% after ded
Mental Health Inpatient	30% after ded	30% after ded	50% after ded
Substance Abuse Inpatient	30% after ded	30% after ded	50% after ded
Outpatient Services			
Outpatient Facility	30% after ded	30% after ded	50% after ded
Lab/X-Ray	PCP-$35 ded waived; SP-$70 ded waived	Lab-$25 ded waived; X-ray-30% after ded	50% after ded
Advanced Radiology	$70 after ded	30% after ded	50% after ded
Mental Health Outpatient	$35 ded waived	$75 ded waived	$75 ded waived
Substance Abuse Outpatient	$35 ded waived	$75 ded waived	$75 ded waived
Emergency Care			
Emergency Room	$600 (waived if admitted) after ded	$500 ded waived	50% after ded
Ambulance	$300 after ded	$500 ded waived	50% after ded
Urgent Care	$70 ded waived	$100 ded waived	$100 ded waived
Recovery/Special Needs			
Home Health Care	$35 after ded; 40 visits/plan yr	$25 ded waived; 40 visits/plan yr	$25 ded waived; 40 visits/plan yr
Skilled Nursing	30% after ded; 200 days/plan yr	30% after ded; 200 days/plan yr	50% after ded; 200 days/plan yr
Durable Medical Equipment	30% after ded	30% after ded	50% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

****Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.**

2018 Summary of Benefits

	Simple Silver EPO	Liberty Advantage Silver EPO 30/70**	Liberty Silver EPO 40/70 NG
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	10/0%/0% IntDed T2-3	15/50/90/150 ded T2-3	15/45/75/200 ded T2-3
Cost Share Information			
Individual/Family Deductible	$7,000/$14,000	$4,000/$8,000	$2,500/$5,000
Individual/Family OOP Limit	$7,000/$14,000 (incl ded)	$7,350/$14,700 (incl ded)	$7,150/$14,300 (incl ded)
Co-Insurance	0%	40%	30%
Office Visits			
Primary Care	$10 ded waived	$30 ded waived	$40 ded waived
Specialist	$50 ded waived	$70 ded waived	$70 ded waived
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	$50 ded waived	$70 ded waived	$70 ded waived
Inpatient Services			
Inpatient Hospital	0% after ded	40% after ded	30% after ded
Mental Health Inpatient	0% after ded	40% after ded	30% after ded
Substance Abuse Inpatient	0% after ded	Rehab-40% after ded	Rehab-30% after ded
Outpatient Services			
Outpatient Facility	0% after ded	40% after ded	30% after ded
Lab/X-Ray	Lab-$25 ded waived; X-ray-0% after	40% after ded	Lab-$20 ded waived; X-ray-30% after ded
Advanced Radiology	0% after ded	40% after ded	30% after ded
Mental Health Outpatient	$50 ded waived	$70 ded waived	$70 ded waived
Substance Abuse Outpatient	$50 ded waived	Rehab-$70 ded waived	Rehab-$70 ded waived
Emergency Care			
Emergency Room	0% after ded	40% after ded	$700 (waived if admitted) ded waived
Ambulance	0% after ded	No charge	No charge
Urgent Care	$100 ded waived	$80 ded waived	$75 ded waived
Recovery/Special Needs			
Home Health Care	$50 ded waived; 40 visits/plan yr	$70 ded waived; 40 visits/contr yr	$70 ded waived; 40 visits/contr yr
Skilled Nursing	0% after ded; 200 days/plan yr	40% after ded; 200 days/contr yr	30% after ded; 200 days/contr yr
Durable Medical Equipment	0% after ded	40% after ded	30% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

****Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.**

2018 Summary of Benefits

	Liberty Prim Adv Silver EPO 2K	Metro Silver EPO 30/60**	Bronze Pro EPO HSA
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	15/35/75 IntDed T2-3	10/65/50%to$800	20%/20%/20% IntDed
Cost Share Information			
Individual/Family Deductible	$2,000/$4,000	$3,000/$6,000	$5,000/$10,000
Individual/Family OOP Limit	$6,000/$12,000 (incl ded)	$7,150/$14,300 (incl ded)	$6,550/$13,100 (incl ded)
Co-Insurance	30%	30%	20%
Office Visits			
Primary Care	$25 ded waived	$30 ded waived	$30 ded waived
Specialist	$50 after ded	$60 ded waived	$60 ded waived
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	$50 after ded	$60 ded waived	20% after ded
Inpatient Services			
Inpatient Hospital	$250/day after ded; $1,250 max/admit	30% after ded	20% after ded
Mental Health Inpatient	$250/day after ded; $1,250 max/admit	30% after ded	20% after ded
Substance Abuse Inpatient	Rehab-$250/day after ded; $1,250 max/admit	Rehab-30% after ded	20% after ded
Outpatient Services			
Outpatient Facility	Hosp-$250 after ded; FS- $150 after ded	30% after ded	20% after ded
Lab/X-Ray	Lab-$50 after ded; X-ray- $90 after ded	Lab-No charge; X-ray-30% after ded	20% after ded
Advanced Radiology	Hosp-$100 after ded; FS-0% after ded	30% after ded	20% after ded
Mental Health Outpatient	$50 ded waived	$60 ded waived	20% after ded
Substance Abuse Outpatient	Rehab-$50 ded waived	Rehab-$60 ded waived	20% after ded
Emergency Care			
Emergency Room	30% after ded	30% after ded	20% after ded
Ambulance	$100 after ded	No charge	20% after ded
Urgent Care	$75 after ded	$80 ded waived	20% after ded
Recovery/Special Needs			
Home Health Care	$50 after ded; 40 visits/contr yr	$60 ded waived; 40 visits/contr yr	20% after ded; 40 visits/plan yr
Skilled Nursing	$250/day after ded; $1,250 max/admit; 200 days/contr yr	30% after ded; 200 days/contr yr	20% after ded; 200 days/plan yr
Durable Medical Equipment	$100 after ded	30% after ded	20% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

****Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.**

2018 Summary of Benefits

	Classic Bronze EPO	Simple Bronze EPO	Liberty Bronze EPO HSA 70% NG
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	20/50/100 IntDed	0%/0%/0% IntDed	30%/30%/30% IntDed
Cost Share Information			
Individual/Family Deductible	$4,000/$8,000	$7,350/$14,700	$3,000/$6,000
Individual/Family OOP Limit	$7,350/$14,700 (incl ded)	$7,350/$14,700 (incl ded)	$6,550/$13,100 (incl ded)
Co-Insurance	50%	0%	30%
Office Visits			
Primary Care	50% after ded	0% after ded	$25 after ded
Specialist	50% after ded	0% after ded	$75 after ded
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Chiropractic Care	50% after ded	0% after ded	$75 after ded
Inpatient Services			
Inpatient Hospital	50% after ded	0% after ded	30% after ded
Mental Health Inpatient	50% after ded	0% after ded	30% after ded
Substance Abuse Inpatient	50% after ded	0% after ded	Rehab-30% after ded
Outpatient Services			
Outpatient Facility	$100 after ded	0% after ded	30% after ded
Lab/X-Ray	50% after ded	0% after ded	30% after ded
Advanced Radiology	50% after ded	0% after ded	30% after ded
Mental Health Outpatient	50% after ded	0% after ded	$75 after ded
Substance Abuse Outpatient	50% after ded	0% after ded	Rehab-$75 after ded
Emergency Care			
Emergency Room	50% after ded	0% after ded	30% after ded
Ambulance	50% after ded	0% after ded	30% after ded
Urgent Care	$100 after ded	0% after ded	30% after ded
Recovery/Special Needs			
Home Health Care	50% after ded; 40 visits/plan yr	0% after ded; 40 visits/plan yr	25% after ded; 40 visits/contr yr
Skilled Nursing	50% after ded; 200 days/plan yr	0% after ded; 200 days/plan yr	30% after ded; 200 days/plan yr
Durable Medical Equipment	50% after ded	0% after ded	30% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

****Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.**

2018 Summary of Benefits

	UnitedHealthcare OXFORD **Metro Bronze EPO HSA 100%****
	In-Network
Prescription Drugs	
Drug Card	0%/0%/0% IntDed
Cost Share Information	
Individual/Family Deductible	$6,550/$13,100
Individual/Family OOP Limit	$6,550/$13,100 (incl ded)
Co-Insurance	0%
Office Visits	
Primary Care	0% after ded
Specialist	0% after ded
Maternity Prenatal/Postnatal Care	No charge
Chiropractic Care	0% after ded
Inpatient Services	
Inpatient Hospital	0% after ded
Mental Health Inpatient	0% after ded
Substance Abuse Inpatient	Rehab-0% after ded
Outpatient Services	
Outpatient Facility	0% after ded
Lab/X-Ray	0% after ded
Advanced Radiology	0% after ded
Mental Health Outpatient	0% after ded
Substance Abuse Outpatient	Rehab-0% after ded
Emergency Care	
Emergency Room	0% after ded
Ambulance	0% after ded
Urgent Care	0% after ded
Recovery/Special Needs	
Home Health Care	0% after ded; 40 visits/contr yr
Skilled Nursing	0% after ded; 200 days/contr yr
Durable Medical Equipment	0% after ded

Please refer to the official Summary of Benefits and Coverage (SBC) for complete summary of coverage.

****Gated plan which requires the selection of Primary Care Physician (PCP) and referrals to see specialists.**