






2019 Summary of Benefits

	 Platinum Pro EPO	 Circle Platinum	 Circle Plus Platinum
	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	\$2,000/\$4,000
Co-Insurance	0%	0%	0%
Lifetime Max	None	None	None
Office Visits			
Primary Care	\$20	\$10	\$10
Specialist	\$35	\$25	\$25
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	\$35; 60 visits/cond/plan yr comb PT/OT/ST	\$25; 60 visits/cond/plan yr comb PT/OT/ST	\$25; 60 visits/cond/plan yr comb PT/OT/ST
Chiropractic Care	\$35	\$25	\$25
Inpatient Services			
Inpatient Hospital	\$500/admit	\$500/admit	\$500/admit
Inpatient Surgery	\$100	\$50	\$50
Maternity Delivery/Inpatient	Delivery-\$100; IP-\$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	\$100	\$100
Outpatient Surgery	\$100	\$50	\$50
Lab/X-Ray	PCP-\$20; SP-\$35	Lab-\$15; X-ray-\$50	Lab-\$15; 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)	\$500	\$500
Ambulance	\$150	\$500	\$500
Urgent Care	\$50	\$75	\$75
Recovery/Special Needs			
Home Health Care	\$20; 40 visits/plan yr	\$25; 40 visits/plan yr	\$25; 40 visits/plan yr
Habilitation services	\$35; 60 visits/cond/plan yr comb PT/OT/ST	\$25; 60 visits/cond/plan yr comb PT/OT/ST	\$25; 60 visits/cond/plan yr comb PT/OT/ST
Skilled Nursing	\$500/admit; 200 days/plan yr	\$500/admit; 200 days/plan yr	\$500/admit; 200 days/plan yr
Durable Medical Equipment	10%	20%	20%
Hospice Services	\$500/admit IP; \$20 OP; 210 days/plan yr	20%; 210 days/plan yr	20%; 210 days/plan yr

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



2019 Summary of Benefits

	 Liberty Advantage Platinum EPO 15/35 G	 Gold Pro EPO	 Gold 25/50/0 Pro EPO
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	5/30/60/150 ded T2-3	10/50/85	10/50/85
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)	\$7,000/\$14,000 (incl ded)
Co-Insurance	10%	0%	0%
Lifetime Max	None	None	None
Office Visits			
Primary Care	\$15 ded waived	\$25	\$25
Specialist	\$35 ded waived	\$40	\$50
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	\$35 ded waived; 60 visits/cal yr combPT/OT/ST	\$40; 60 visits/cond/plan yr comb PT/OT/ST	\$50; 60 visits/cond/plan yr comb PT/OT/ST
Chiropractic Care	\$35 ded waived	\$40	\$50
Inpatient Services			
Inpatient Hospital	10% after ded	\$500/admit	\$500/admit
Inpatient Surgery	10% after ded	\$100	\$100
Maternity Delivery/Inpatient	10% after ded	Delivery-\$100; IP-\$500/admit	Delivery-\$100; IP-\$500/admit
Mental Health Inpatient	10% after ded	\$500/admit	\$500/admit
Substance Abuse Inpatient	Rehab-10% after ded	\$500/admit	\$500/admit
Outpatient Services			
Outpatient Facility	10% after ded	\$300	\$300
Outpatient Surgery	10% after ded	\$100	\$100
Lab/X-Ray	10% after ded	PCP-\$25; SP-\$40	PCP-\$25; SP-\$50
Advanced Radiology	10% after ded	\$40	\$50
Mental Health Outpatient	\$35 ded waived	\$25	\$25
Substance Abuse Outpatient	Rehab-\$35 ded waived	\$25	\$25
Emergency Care			
Emergency Room	10% after ded	\$350 (waived if admitted)	\$350 (waived if admitted)
Ambulance	No charge	\$150	\$150
Urgent Care	\$35 ded waived	\$60	\$60
Recovery/Special Needs			
Home Health Care	\$35 ded waived; 40 visits/cal yr	\$25; 40 visits/plan yr	\$25; 40 visits/plan yr
Habilitation services	\$35 ded waived; 60 visits/cal yr combPT/OT/ST	\$40; 60 visits/cond/plan yr comb PT/OT/ST	\$50; 60 visits/cond/plan yr comb PT/OT/ST
Skilled Nursing	10% after ded; 200 days/cal yr	\$500/admit; 200 days/plan yr	\$500/admit; 200 days/plan yr
Durable Medical Equipment	10% after ded	15%	15%
Hospice Services	10% after ded	\$500/admit IP; \$25 OP; 210 days/plan yr	\$500/admit IP; \$25 OP; 210 days/plan yr

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



2019 Summary of Benefits

	oscar Circle Gold	oscar Circle Plus Gold	oscar Circle Gold 750
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	10/25/100	10/25/100	15/50/100/100 ded T2-3
Cost Share Information			
Individual/Family Deductible	N/A	N/A	\$750/\$1,500
Individual/Family OOP Limit	\$5,000/\$10,000	\$5,000/\$10,000	\$7,500/\$15,000 (incl ded)
Co-Insurance	0%	0%	20%
Lifetime Max	None	None	None
Office Visits			
Primary Care	\$25	\$25	\$25 ded waived
Specialist	\$50	\$50	\$50 ded waived
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	\$25; 60 visits/cond/plan yr comb PT/OT/ST	\$25; 60 visits/cond/plan yr comb PT/OT/ST	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST
Chiropractic Care	\$25	\$25	\$25 ded waived
Inpatient Services			
Inpatient Hospital	\$500/day; 5 days/admit	\$500/day; 5 days/admit	20% after ded
Inpatient Surgery	\$150	\$150	20% after ded
Maternity Delivery/Inpatient	\$500/day; 5 days/admit	\$500/day; 5 days/admit	20% after ded
Mental Health Inpatient	\$500/day; 5 days/admit	\$500/day; 5 days/admit	20% after ded
Substance Abuse Inpatient	\$500/day; 5 days/admit	\$500/day; 5 days/admit	20% after ded
Outpatient Services			
Outpatient Facility	\$150	\$150	20% after ded
Outpatient Surgery	\$150	\$150	20% after ded
Lab/X-Ray	\$50	\$50	20% coins subject to ded (x-ray) \$50 copay/visit not subject to ded (lab work)
Advanced Radiology	\$125	\$125	20% after ded
Mental Health Outpatient	\$25	\$25	\$25 ded waived
Substance Abuse Outpatient	\$25	\$25	\$25 ded waived
Emergency Care			
Emergency Room	\$750	\$750	20% after ded
Ambulance	\$750	\$750	20% after ded
Urgent Care	\$75	\$75	\$75 ded waived
Recovery/Special Needs			
Home Health Care	\$50; 40 visits/plan yr	\$50; 40 visits/plan yr	\$50 ded waived; 40 visits/plan yr
Habilitation services	\$25; 60 visits/cond/plan yr comb PT/OT/ST	\$25; 60 visits/cond/plan yr comb PT/OT/ST	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST
Skilled Nursing	\$500/day; 5 days/admit; 200 days/plan yr	\$500/day; 5 days/admit; 200 days/plan yr	20% after ded; 200 days/plan yr
Durable Medical Equipment	20%	20%	20% after ded
Hospice Services	20%; 210 days/plan yr	20%; 210 days/plan yr	20% after ded; 210 days/plan yr

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



2019 Summary of Benefits

	OSCAR Circle Plus Gold 750	OSCAR Circle Gold 2000	oscar Circle Plus Gold 2000
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	15/50/100/100 ded T2-3	10/50/100/150 ded T2-3	10/50/100/150 ded T2-3
Cost Share Information			
Individual/Family Deductible	\$750/\$1,500	\$2,000/\$4,000	\$2,000/\$4,000
Individual/Family OOP Limit	\$7,500/\$15,000 (incl ded)	\$7,000/\$14,000 (incl ded)	\$7,000/\$14,000 (incl ded)
Co-Insurance	20%	20%	20%
Lifetime Max	None	None	None
Office Visits			
Primary Care	\$25 ded waived	\$25 ded waived	\$25 ded waived
Specialist	\$50 ded waived	\$50 ded waived	\$50 ded waived
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST
Chiropractic Care	\$25 ded waived	\$25 ded waived	\$25 ded waived
Inpatient Services			
Inpatient Hospital	20% after ded	20% after ded	20% after ded
Inpatient Surgery	20% after ded	20% after ded	20% after ded
Maternity Delivery/Inpatient	20% after ded	20% after ded	20% after ded
Mental Health Inpatient	20% after ded	20% after ded	20% after ded
Substance Abuse Inpatient	20% after ded	20% after ded	20% after ded
Outpatient Services			
Outpatient Facility	20% after ded	20% after ded	20% after ded
Outpatient Surgery	20% after ded	20% after ded	20% after ded
Lab/X-Ray	20% coins subject to ded (x-ray) \$50 copay/visit not subject to ded (lab work)	20% coins subject to ded (x-ray) \$50 copay/visit not subject to ded (lab work)	20% coins subject to ded (x-ray) \$50 copay/visit not subject to ded (lab work)
Advanced Radiology	20% after ded	20% after ded	20% after ded
Mental Health Outpatient	\$25 ded waived	\$25 ded waived	\$25 ded waived
Substance Abuse Outpatient	\$25 ded waived	\$25 ded waived	\$25 ded waived
Emergency Care			
Emergency Room	20% after ded	\$250 ded waived	\$250 ded waived
Ambulance	20% after ded	\$250 ded waived	\$250 ded waived
Urgent Care	\$75 ded waived	\$75 ded waived	\$75 ded waived
Recovery/Special Needs			
Home Health Care	\$50 ded waived; 40 visits/plan yr	\$50 ded waived; 40 visits/plan yr	\$50 ded waived; 40 visits/plan yr
Habilitation services	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST
Skilled Nursing	20% after ded; 200 days/plan yr	20% after ded; 200 days/plan yr	20% after ded; 200 days/plan yr
Durable Medical Equipment	20% after ded	20% after ded	20% after ded
Hospice Services	20% after ded; 210 days/plan yr	20% after ded; 210 days/plan yr	20% after ded; 210 days/plan yr

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



2019 Summary of Benefits

	 Liberty Gold EPO 30/60 NG	 Liberty Gold EPO 30/60 G	 Metro Gold EPO 25/40 NG
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	15/45/75/100 ded T2-3	15/35/75/100 ded T2-3	10/65/90/100 ded T2-3
Cost Share Information			
Individual/Family Deductible	\$2,000/\$4,000	\$1,000/\$2,000	\$1,250/\$2,500
Individual/Family OOP Limit	\$7,900/\$15,800 (incl ded)	\$4,500/\$9,000 (incl ded)	\$5,000/\$10,000 (incl ded)
Co-Insurance	30%	0%	20%
Lifetime Max	None	None	None
Office Visits			
Primary Care	\$30 ded waived	\$30 ded waived	\$25 ded waived
Specialist	\$60 ded waived	\$60 ded waived	\$40 ded waived
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	\$60 ded waived; 60 visits/cal yr comb PT/OT/ST	\$60 ded waived; 60 visits/cal yr comb PT/OT/ST	\$40 ded waived; 60 visits/cal yr comb PT/OT/ST
Chiropractic Care	\$60 ded waived	\$60 ded waived	\$40 ded waived
Inpatient Services			
Inpatient Hospital	30% after ded	\$500/day after ded; \$2,000 max/admit	20% after ded
Inpatient Surgery	30% after ded	0% after ded	20% after ded
Maternity Delivery/Inpatient	30% after ded	\$500/day after ded; \$2,000 max/admit	20% after ded
Mental Health Inpatient	30% after ded	\$500/day after ded; \$2,000 max/admit	20% after ded
Substance Abuse Inpatient	Rehab-30% after ded	Rehab-\$500/day after ded; \$2,000 max/admit	Rehab-20% after ded
Outpatient Services			
Outpatient Facility	30% after ded	Hosp-\$250 after ded; FS-\$150 after ded	Hosp-\$500 after ded; FS-\$200 after ded
Outpatient Surgery	30% after ded	Included in Outpatient Facility	20% after ded
Lab/X-Ray	Lab-No charge; X-ray-30% after ded	Lab-No charge; X-ray-\$35 after ded	Lab-\$15 ded waived; X-ray-\$50 after ded
Advanced Radiology	30% after ded	\$100 after ded	\$150 after ded
Mental Health Outpatient	\$60 ded waived	\$60 ded waived	\$40 ded waived
Substance Abuse Outpatient	Rehab-\$60 ded waived	Rehab-\$60 ded waived	Rehab-\$40 ded waived
Emergency Care			
Emergency Room	\$500 (waived if admitted) ded waived	\$500 (waived if admitted) ded waived	\$400 (waived if admitted) ded waived
Ambulance	No charge	No charge	No charge
Urgent Care	\$75 ded waived	\$75 ded waived	\$65 ded waived
Recovery/Special Needs			
Home Health Care	\$60 ded waived; 40 visits/cal yr	\$60 ded waived; 40 visits/cal yr	\$40 ded waived; 40 visits/cal yr
Habilitation services	\$60 ded waived; 60 visits/cal yr comb PT/OT/ST	\$60 ded waived; 60 visits/cal yr comb PT/OT/ST	\$40 ded waived; 60 visits/cal yr comb PT/OT/ST
Skilled Nursing	30% after ded; 200 days/cal yr	\$500/day after ded; \$2,000 max/admit; 200 days/cal yr	20% after ded; 200 days/cal yr
Durable Medical Equipment	30% after ded	0% after ded	20% after ded
Hospice Services	30% after ded	\$500/day after ded; \$2,000 max/admit	20% after ded

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



2019 Summary of Benefits

	 Metro Gold EPO 25/40 G	 Silver Pro EPO	 Silver 40/75/4700 Pro EPO
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	10/65/90/100 ded T2-3	20/60/110	20/60/110
Cost Share Information			
Individual/Family Deductible	\$1,250/\$2,500	\$2,950/\$5,900	\$4,700/\$9,400
Individual/Family OOP Limit	\$5,500/\$11,000 (incl ded)	\$7,900/\$15,800 (incl ded)	\$7,900/\$15,800 (incl ded)
Co-Insurance	20%	40%	45%
Lifetime Max	None	None	None
Office Visits			
Primary Care	\$25 ded waived	\$35 ded waived	\$40 ded waived
Specialist	\$40 ded waived	\$70 ded waived	\$75 ded waived
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	\$40 ded waived; 60 visits/cal yr comb PT/OT/ST	\$70 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	\$75 ded waived; 60 visits/cond/plan yr comb PT/OT/ST
Chiropractic Care	\$40 ded waived	\$70 ded waived	\$75 ded waived
Inpatient Services			
Inpatient Hospital	20% after ded	40% after ded	45% after ded
Inpatient Surgery	20% after ded	\$200	\$200
Maternity Delivery/Inpatient	20% after ded	Delivery-\$200 after ded; IP-40% after ded	Delivery-\$200 after ded; IP-45% after ded
Mental Health Inpatient	20% after ded	40% after ded	45% after ded
Substance Abuse Inpatient	Rehab-20% after ded	40% after ded	45% after ded
Outpatient Services			
Outpatient Facility	Hosp-\$500 after ded; FS-\$200 after ded	40% after ded	45% after ded
Outpatient Surgery	20% after ded	\$200 after ded	\$200 after ded
Lab/X-Ray	Lab-\$15 ded waived; X-ray-\$50 after ded	PCP-\$35 ded waived; SP-\$70 ded waived	PCP-\$40 ded waived; SP-\$75 ded waived
Advanced Radiology	\$150 after ded	\$70 after ded	\$75 after ded
Mental Health Outpatient	\$40 ded waived	\$35 ded waived	\$40 ded waived
Substance Abuse Outpatient	Rehab-\$40 ded waived	\$35 ded waived	\$40 ded waived
Emergency Care			
Emergency Room	\$500 (waived if admitted) ded waived	\$600 (waived if admitted) after ded	\$600 (waived if admitted) after ded
Ambulance	No charge	\$300 after ded	\$300 after ded
Urgent Care	\$65 ded waived	\$70 ded waived	\$75 ded waived
Recovery/Special Needs			
Home Health Care	\$40 ded waived; 40 visits/cal yr	\$35 after ded; 40 visits/plan yr	\$40 after ded; 40 visits/plan yr
Habilitation services	\$40 ded waived; 60 visits/cal yr comb PT/OT/ST	\$70 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	\$75 ded waived; 60 visits/cond/plan yr comb PT/OT/ST
Skilled Nursing	20% after ded; 200 days/cal yr	40% after ded; 200 days/plan yr	45% after ded; 200 days/plan yr
Durable Medical Equipment	20% after ded	40% after ded	45% after ded
Hospice Services	20% after ded	40% after ded IP; \$35 ded waived OP; 210 days/plan yr	45% after ded IP; \$40 ded waived OP; 210 days/plan yr

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



2019 Summary of Benefits

	oscar Circle Silver	oscar Circle Plus Silver	oscar Circle Silver 2700
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	20/50/50%/100 ded T3	20/50/50%/100 ded T3	20/50/100
Cost Share Information			
Individual/Family Deductible	N/A	N/A	\$2,700/\$5,400
Individual/Family OOP Limit	\$7,900/\$15,800	\$7,900/\$15,800	\$7,900/\$15,800 (incl ded)
Co-Insurance	0%	0%	30%
Lifetime Max	None	None	None
Office Visits			
Primary Care	\$50	\$50	\$40 ded waived
Specialist	\$75	\$75	\$70 ded waived
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	\$50; 60 visits/cond/plan yr comb PT/OT/ST	\$50; 60 visits/cond/plan yr comb PT/OT/ST	\$40 ded waived; 60 visits/cond/plan yr comb PT/OT/ST
Chiropractic Care	\$50	\$50	\$40 ded waived
Inpatient Services			
Inpatient Hospital	\$1,000/admit	\$1,000/admit	30% after ded
Inpatient Surgery	\$250	\$250	30% after ded
Maternity Delivery/Inpatient	\$1,000/admit	\$1,000/admit	30% after ded
Mental Health Inpatient	\$1,000/admit	\$1,000/admit	30% after ded
Substance Abuse Inpatient	\$1,000/admit	\$1,000/admit	30% after ded
Outpatient Services			
Outpatient Facility	\$500	\$500	30% after ded
Outpatient Surgery	\$250	\$250	30% after ded
Lab/X-Ray	\$75	\$75	30% coins subject to ded (x-ray), \$70.00 copay/visit not subject to ded (lab work)
Advanced Radiology	\$150	\$150	30% after ded
Mental Health Outpatient	\$50	\$50	\$40 ded waived
Substance Abuse Outpatient	\$50	\$50	\$40 ded waived
Emergency Care			
Emergency Room	\$650	\$650	30% after ded
Ambulance	\$650	\$650	30% after ded
Urgent Care	\$75	\$75	\$75 ded waived
Recovery/Special Needs			
Home Health Care	\$75; 40 visits/plan yr	\$75; 40 visits/plan yr	\$70 ded waived; 40 visits/plan yr
Habilitation services	\$50; 60 visits/cond/plan yr comb PT/OT/ST	\$50; 60 visits/cond/plan yr comb PT/OT/ST	\$40 ded waived; 60 visits/cond/plan yr comb PT/OT/ST
Skilled Nursing	\$1,000/admit; 200 days/plan yr	\$1,000/admit; 200 days/plan yr	30% after ded; 200 days/plan yr
Durable Medical Equipment	20%	20%	30% after ded
Hospice Services	20%; 210 days/plan yr	20%; 210 days/plan yr	30% after ded; 210 days/plan yr

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



2019 Summary of Benefits

	oscar Circle Plus Silver 2700	oscar Circle Silver 4500	oscar Circle Plus Silver 4500
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	20/50/100	10/50%/50% IntDed T2-3	10/50%/50% IntDed T2-3
Cost Share Information			
Individual/Family Deductible	\$2,700/\$5,400	\$4,500/\$9,000	\$4,500/\$9,000
Individual/Family OOP Limit	\$7,900/\$15,800 (incl ded)	\$7,000/\$14,000 (incl ded)	\$7,000/\$14,000 (incl ded)
Co-Insurance	30%	50%	50%
Lifetime Max	None	None	None
Office Visits			
Primary Care	\$40 ded waived	\$25 ded waived	\$25 ded waived
Specialist	\$70 ded waived	\$75 ded waived	\$75 ded waived
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	\$40 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST
Chiropractic Care	\$40 ded waived	\$25 ded waived	\$25 ded waived
Inpatient Services			
Inpatient Hospital	30% after ded	50% after ded	50% after ded
Inpatient Surgery	30% after ded	50% after ded	50% after ded
Maternity Delivery/Inpatient	30% after ded	50% after ded	50% after ded
Mental Health Inpatient	30% after ded	50% after ded	50% after ded
Substance Abuse Inpatient	30% after ded	50% after ded	50% after ded
Outpatient Services			
Outpatient Facility	30% after ded	50% after ded	50% after ded
Outpatient Surgery	30% after ded	50% after ded	50% after ded
Lab/X-Ray	30% coins subject to ded (x-ray), \$70.00 copay/visit not subject to ded (lab work)	50% coins subject to ded (x-ray), \$75.00 copay/visit not subject to ded (lab work)	50% coins subject to ded (x-ray), \$75.00 copay/visit not subject to ded (lab work)
Advanced Radiology	30% after ded	50% after ded	50% after ded
Mental Health Outpatient	\$40 ded waived	\$25 ded waived	\$25 ded waived
Substance Abuse Outpatient	\$40 ded waived	\$25 ded waived	\$25 ded waived
Emergency Care			
Emergency Room	30% after ded	50% after ded	50% after ded
Ambulance	30% after ded	50% after ded	50% after ded
Urgent Care	\$75 ded waived	\$75 ded waived	\$75 ded waived
Recovery/Special Needs			
Home Health Care	\$70 ded waived; 40 visits/plan yr	\$75 ded waived; 40 visits/plan yr	\$75 ded waived; 40 visits/plan yr
Habilitation services	\$40 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST	\$25 ded waived; 60 visits/cond/plan yr comb PT/OT/ST
Skilled Nursing	30% after ded; 200 days/plan yr	50% after ded; 200 days/plan yr	50% after ded; 200 days/plan yr
Durable Medical Equipment	30% after ded	50% after ded	50% after ded
Hospice Services	30% after ded; 210 days/plan yr	50% after ded; 210 days/plan yr	50% after ded; 210 days/plan yr



2019 Summary of Benefits

	OSCAR Circle Silver HSA 3000	OSCAR Circle Plus Silver HSA 3000	 Liberty Silver 40/70 NG
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	20%/20%/20% IntDed	20%/20%/20% IntDed	15/45/75/200 ded T2-3
Cost Share Information			
Individual/Family Deductible	\$3,000/\$6,000	\$3,000/\$6,000	\$2,500/\$5,000
Individual/Family OOP Limit	\$5,000/\$10,000 (incl ded)	\$5,000/\$10,000 (incl ded)	\$7,900/\$15,800 (incl ded)
Co-Insurance	20%	20%	30%
Lifetime Max	None	None	None
Office Visits			
Primary Care	20% after ded	20% after ded	\$40 ded waived
Specialist	20% after ded	20% after ded	\$70 ded waived
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	20% after ded; 60 visits/cond/plan yr comb PT/OT/ST	20% after ded; 60 visits/cond/plan yr comb PT/OT/ST	\$70 ded waived; 60 visits/cal yr comb PT/OT/ST
Chiropractic Care	20% after ded	20% after ded	\$70 ded waived
Inpatient Services			
Inpatient Hospital	20% after ded	20% after ded	30% after ded
Inpatient Surgery	20% after ded	20% after ded	30% after ded
Maternity Delivery/Inpatient	20% after ded	20% after ded	30% after ded
Mental Health Inpatient	20% after ded	20% after ded	30% after ded
Substance Abuse Inpatient	20% after ded	20% after ded	Rehab-30% after ded
Outpatient Services			
Outpatient Facility	20% after ded	20% after ded	30% after ded
Outpatient Surgery	20% after ded	20% after ded	30% after ded
Lab/X-Ray	20% after ded	20% after ded	Lab-\$20 ded waived; X-ray-30% after ded
Advanced Radiology	20% after ded	20% after ded	30% after ded
Mental Health Outpatient	20% after ded	20% after ded	\$70 ded waived
Substance Abuse Outpatient	20% after ded	20% after ded	Rehab-\$70 ded waived
Emergency Care			
Emergency Room	20% after ded	20% after ded	30% after ded
Ambulance	20% after ded	20% after ded	No charge
Urgent Care	20% after ded	20% after ded	\$75 ded waived
Recovery/Special Needs			
Home Health Care	20% after ded; 40 visits/plan yr	20% after ded; 40 visits/plan yr	\$70 ded waived; 40 visits/cal yr
Habilitation services	20% after ded; 60 visits/cond/plan yr comb PT/OT/ST	20% after ded; 60 visits/cond/plan yr comb PT/OT/ST	\$70 ded waived; 60 visits/cal yr comb PT/OT/ST
Skilled Nursing	20% after ded; 200 days/plan yr	20% after ded; 200 days/plan yr	30% after ded; 200 days/cal yr
Durable Medical Equipment	20% after ded	20% after ded	30% after ded
Hospice Services	20% after ded; 210 days/plan yr	20% after ded; 210 days/plan yr	30% after ded

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






2019 Summary of Benefits

	 Liberty Advantage Silver EPO 30/70 G	 Metro Silver EPO 30/80 NG	 Metro Silver EPO 30/80 G
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	15/50/90/150 ded T2-3	10/65/90/100 ded T2-3	10/65/90/100 ded T2-3
Cost Share Information			
Individual/Family Deductible	\$4,000/\$8,000	\$3,000/\$6,000	\$3,000/\$6,000
Individual/Family OOP Limit	\$7,350/\$14,700 (incl ded)	\$7,900/\$15,800 (incl ded)	\$7,900/\$15,800 (incl ded)
Co-Insurance	40%	30%	30%
Lifetime Max	None	None	None
Office Visits			
Primary Care	\$30 ded waived	\$30 ded waived	\$30 ded waived
Specialist	\$70 ded waived	\$80 ded waived	\$80 ded waived
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	\$70 ded waived; 60 visits/cal yr comb PT/OT/ST	\$80 ded waived; 60 visits/cal yr comb PT/OT/ST	\$80 ded waived; 60 visits/cal yr comb PT/OT/ST
Chiropractic Care	\$70 ded waived	\$80 ded waived	\$80 ded waived
Inpatient Services			
Inpatient Hospital	40% after ded	30% after ded	30% after ded
Inpatient Surgery	40% after ded	30% after ded	30% after ded
Maternity Delivery/Inpatient	40% after ded	30% after ded	30% after ded
Mental Health Inpatient	40% after ded	30% after ded	30% after ded
Substance Abuse Inpatient	Rehab-40% after ded	Rehab-30% after ded	Rehab-30% after ded
Outpatient Services			
Outpatient Facility	40% after ded	30% after ded	30% after ded
Outpatient Surgery	40% after ded	30% after ded	30% after ded
Lab/X-Ray	40% after ded	Lab-\$15 ded waived; X-ray-30% after ded	Lab-\$15 ded waived; X-ray-30% after ded
Advanced Radiology	40% after ded	30% after ded	30% after ded
Mental Health Outpatient	\$70 ded waived	\$80 ded waived	\$80 ded waived
Substance Abuse Outpatient	Rehab-\$70 ded waived	Rehab-\$80 ded waived	Rehab-\$80 ded waived
Emergency Care			
Emergency Room	40% after ded	30% after ded	30% after ded
Ambulance	No charge	No charge	No charge
Urgent Care	\$70 ded waived	\$80 ded waived	\$80 ded waived
Recovery/Special Needs			
Home Health Care	\$70 ded waived; 40 visits/cal yr	\$80 ded waived; 40 visits/cal yr	\$80 ded waived; 40 visits/cal yr
Habilitation services	\$70 ded waived; 60 visits/cal yr comb PT/OT/ST	\$80 ded waived; 60 visits/cal yr comb PT/OT/ST	\$80 ded waived; 60 visits/cal yr comb PT/OT/ST
Skilled Nursing	40% after ded; 200 days/cal yr	30% after ded; 200 days/cal yr	30% after ded; 200 days/cal yr
Durable Medical Equipment	40% after ded	30% after ded	30% after ded
Hospice Services	40% after ded	30% after ded	30% after ded

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



2019 Summary of Benefits

	 Bronze Pro EPO HSA	 Bronze 6650 Pro EPO HSA	 Circle Bronze 4000
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	20%/20%/20% IntDed	0%/0%/0% IntDed	20/50/100 IntDed
Cost Share Information			
Individual/Family Deductible	\$4,000/\$8,000	\$6,650/\$13,300	\$4,000/\$8,000
Individual/Family OOP Limit	\$6,650/\$13,300 (incl ded)	\$6,650/\$13,300 (incl ded)	\$7,900/\$15,800 (incl ded)
Co-Insurance	20%	0%	50%
Lifetime Max	None	None	None
Office Visits			
Primary Care	20% after ded	0% after ded	50% after ded
Specialist	20% after ded	0% after ded	50% after ded
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	20% after ded; 60 visits/cond/plan yr comb PT/OT/ST	0% after ded; 60 visits/cond/plan yr comb PT/OT/ST	50% after ded; 60 visits/cond/plan yr comb PT/OT/ST
Chiropractic Care	20% after ded	0% after ded	50% after ded
Inpatient Services			
Inpatient Hospital	20% after ded	0% after ded	50% after ded
Inpatient Surgery	20% after ded	0% after ded	50% after ded
Maternity Delivery/Inpatient	20% after ded	0% after ded	50% after ded
Mental Health Inpatient	20% after ded	0% after ded	50% after ded
Substance Abuse Inpatient	20% after ded	0% after ded	50% after ded
Outpatient Services			
Outpatient Facility	20% after ded	0% after ded	50% after ded
Outpatient Surgery	20% after ded	0% after ded	50% after ded
Lab/X-Ray	20% after ded	0% after ded	50% after ded
Advanced Radiology	20% after ded	0% after ded	50% after ded
Mental Health Outpatient	20% after ded	0% after ded	50% after ded
Substance Abuse Outpatient	20% after ded	0% after ded	50% after ded
Emergency Care			
Emergency Room	20% after ded	0% after ded	50% after ded
Ambulance	20% after ded	0% after ded	50% after ded
Urgent Care	20% after ded	0% after ded	\$75 ded waived
Recovery/Special Needs			
Home Health Care	20% after ded; 40 visits/plan yr	0% after ded; 40 visits/plan yr	50% after ded; 40 visits/plan yr
Habilitation services	20% after ded; 60 visits/cond/plan yr comb PT/OT/ST	0% after ded; 60 visits/cond/plan yr comb PT/OT/ST	50% after ded; 60 visits/cond/plan yr comb PT/OT/ST
Skilled Nursing	20% after ded; 200 days/plan yr	0% after ded; 200 days/plan yr	50% after ded; 200 days/plan yr
Durable Medical Equipment	20% after ded	0% after ded	50% after ded
Hospice Services	20% after ded; 210 days/plan yr	0% after ded; 210 days/plan yr	50% after ded; 210 days/plan yr

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



2019 Summary of Benefits

	 Circle Plus Bronze 4000	 Circle Bronze 7900	 Circle Plus Bronze 7900
	In-Network	In-Network	In-Network
Prescription Drugs			
Drug Card	20/50/100 IntDed	0%/0%/0% IntDed	0%/0%/0% IntDed
Cost Share Information			
Individual/Family Deductible	\$4,000/\$8,000	\$7,900/\$15,800	\$7,900/\$15,800
Individual/Family OOP Limit	\$7,900/\$15,800 (incl ded)	\$7,900/\$15,800 (incl ded)	\$7,900/\$15,800 (incl ded)
Co-Insurance	50%	0%	0%
Lifetime Max	None	None	None
Office Visits			
Primary Care	50% after ded	0% after ded	0% after ded
Specialist	50% after ded	0% after ded	0% after ded
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge
Rehabilitation Services	50% after ded; 60 visits/cond/plan yr comb PT/OT/ST	0% after ded; 60 visits/cond/plan yr comb PT/OT/ST	0% after ded; 60 visits/cond/plan yr comb PT/OT/ST
Chiropractic Care	50% after ded	0% after ded	0% after ded
Inpatient Services			
Inpatient Hospital	50% after ded	0% after ded	0% after ded
Inpatient Surgery	50% after ded	0% after ded	0% after ded
Maternity Delivery/Inpatient	50% after ded	0% after ded	0% after ded
Mental Health Inpatient	50% after ded	0% after ded	0% after ded
Substance Abuse Inpatient	50% after ded	0% after ded	0% after ded
Outpatient Services			
Outpatient Facility	50% after ded	0% after ded	0% after ded
Outpatient Surgery	50% after ded	0% after ded	0% after ded
Lab/X-Ray	50% after ded	0% after ded	0% after ded
Advanced Radiology	50% after ded	0% after ded	0% after ded
Mental Health Outpatient	50% after ded	0% after ded	0% after ded
Substance Abuse Outpatient	50% after ded	0% after ded	0% after ded
Emergency Care			
Emergency Room	50% after ded	0% after ded	0% after ded
Ambulance	50% after ded	0% after ded	0% after ded
Urgent Care	\$75 ded waived	\$75 ded waived	\$75 ded waived
Recovery/Special Needs			
Home Health Care	50% after ded; 40 visits/plan yr	0% after ded; 40 visits/plan yr	0% after ded; 40 visits/plan yr
Habilitation services	50% after ded; 60 visits/cond/plan yr comb PT/OT/ST	0% after ded; 60 visits/cond/plan yr comb PT/OT/ST	0% after ded; 60 visits/cond/plan yr comb PT/OT/ST
Skilled Nursing	50% after ded; 200 days/plan yr	0% after ded; 200 days/plan yr	0% after ded; 200 days/plan yr
Durable Medical Equipment	50% after ded	0% after ded	0% after ded
Hospice Services	50% after ded; 210 days/plan yr	0% after ded; 210 days/plan yr	0% after ded; 210 days/plan yr

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



2019 Summary of Benefits

	 Circle Bronze HSA 6650	 Circle Plus Bronze HSA 6650	 Liberty Bronze EPO HSA 3300 NG	 Metro Bronze EPO HSA 6550 G
	In-Network	In-Network	In-Network	In-Network
Prescription Drugs				
Drug Card	0%/0%/0% IntDed	0%/0%/0% IntDed	30%/30%/30% IntDed	0%/0%/0% IntDed
Cost Share Information				
Individual/Family Deductible	\$6,650/\$13,300	\$6,650/\$13,300	\$3,300/\$6,600	\$6,550/\$13,100
Individual/Family OOP Limit	\$6,650/\$13,300 (incl ded)	\$6,650/\$13,300 (incl ded)	\$6,700/\$13,400 (incl ded)	\$6,700/\$13,400 (incl ded)
Co-Insurance	0%	0%	30%	0%
Lifetime Max	None	None	None	None
Office Visits				
Primary Care	0% after ded	0% after ded	\$25 after ded	0% after ded
Specialist	0% after ded	0% after ded	\$75 after ded	0% after ded
Adult Preventive Care	No charge	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge	No charge
Maternity Prenatal/Postnatal Care	No charge	No charge	No charge	No charge
Rehabilitation Services	0% after ded; 60 visits/cond/plan yr comb PT/OT/ST	0% after ded; 60 visits/cond/plan yr comb PT/OT/ST	\$75 after ded; 60 visits/cal yr comb PT/OT/ST	0% after ded; 60 visits/cal yr comb PT/OT/ST
Chiropractic Care	0% after ded	0% after ded	\$75 after ded	0% after ded
Inpatient Services				
Inpatient Hospital	0% after ded	0% after ded	30% after ded	0% after ded
Inpatient Surgery	0% after ded	0% after ded	30% after ded	0% after ded
Maternity Delivery/Inpatient	0% after ded	0% after ded	30% after ded	0% after ded
Mental Health Inpatient	0% after ded	0% after ded	30% after ded	0% after ded
Substance Abuse Inpatient	0% after ded	0% after ded	Rehab-30% after ded	Rehab-0% after ded
Outpatient Services				
Outpatient Facility	0% after ded	0% after ded	30% after ded	0% after ded
Outpatient Surgery	0% after ded	0% after ded	30% after ded	0% after ded
Lab/X-Ray	0% after ded	0% after ded	30% after ded	0% after ded
Advanced Radiology	0% after ded	0% after ded	30% after ded	0% after ded
Mental Health Outpatient	0% after ded	0% after ded	\$75 after ded	0% after ded
Substance Abuse Outpatient	0% after ded	0% after ded	Rehab-\$75 after ded	Rehab-0% after ded
Emergency Care				
Emergency Room	0% after ded	0% after ded	30% after ded	0% after ded
Ambulance	0% after ded	0% after ded	30% after ded	0% after ded
Urgent Care	0% after ded	0% after ded	30% after ded	0% after ded
Recovery/Special Needs				
Home Health Care	0% after ded; 40 visits/plan yr	0% after ded; 40 visits/plan yr	\$75 after ded; 40 visits/cal yr	0% after ded; 40 visits/cal yr
Habilitation services	0% after ded; 60 visits/cond/plan yr comb PT/OT/ST	0% after ded; 60 visits/cond/plan yr comb PT/OT/ST	\$75 after ded; 60 visits/cal yr comb PT/OT/ST	0% after ded; 60 visits/cal yr comb PT/OT/ST
Skilled Nursing	0% after ded; 200 days/plan yr	0% after ded; 200 days/plan yr	30% after ded; 200 days/cal yr	0% after ded; 200 days/cal yr
Durable Medical Equipment	0% after ded	0% after ded	30% after ded	0% after ded
Hospice Services	0% after ded; 210 days/plan yr	0% after ded; 210 days/plan yr	30% after ded	0% after ded

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