Current Plans 2026	Plan #1 (OX_P1 FS) Oxford Freedom Silver EPO-H.S.A PCP Lookup: www.oxhp.com	Plan #2 (OX_P2 LG) Oxford Liberty Gold EPO PCP Lookup: www.oxhp.com	Plan #3 (OX_P3 FP) Oxford Freedom Platinum EPO PCP Lookup: www.oxhp.com	Plan #4 (OX_P4 MS) Oxford Metro Silver EPO PCP Lookup: www.oxhp.com
Single:	**$1,354.74**	**$1,519.29**	**$1,886.77**	**$1,277.96**
Parent/Child(ren):	**$2,280.58**	**$2,561.40**	**$3,186.66**	**$2,155.52**
Couple:	**$2,665.61**	**$3,000.18**	**$3,735.14**	**$2,523.00**
Family:	**$3,768.05**	**$4,235.35**	**$5,287.34**	**$3,554.14**
Referrals	No Referrals Required	No Referrals Required	No Referrals Required	No Referrals Required
Annual Deductible (Ind/Fam)	In Network: $2,500/$5,000 NO Out-of-Network	In Network: $1,800/$3,600 NO Out-of-Network	In Network: $0 NO Out-of-Network	In Network: $3,750/$7,500 NO Out-of-Network
CoInsurance ** (YOUR SHARE OF COST)	In Network: 40% After Deductible NO Out-of-Network	In Network: 30% After Deductible NO Out-of-Network	In Network: 0% NO Out-of-Network	In Network: 40% NO Out-of-Network
Out Of Pocket Max (Ind/Fam)	In Network: $8,000/$16,000 NO Out-of-Network	In Network: $8,000/$16,000 NO Out-of-Network	In Network: $3,250/$6,500 NO Out-of-Network	In Network: $9,450/$18,900 NO Out-of-Network
Office Co-payments	PCP - $0 / Spec - $0 Subject to Deductible and CoInsurance** NO Out-of-Network	PCP - $30 / Spec - $60 NO Out-of-Network	PCP - $20 / Spec - $40 NO Out-of-Network	PCP - $30 / Spec - $80 NO Out-of-Network
Hospitals	In-Network: Subject to Deductible & Co-Insurance ** NO Out-of-Network	In-Network: 30% Coinsurance ** NO Out-of-Network	In-Network: $400 Copay Per Admission NO Out-of-Network	In-Network: 40% Coinsurance ** NO Out-of-Network
Prescription Benefits	Generic: $10 CoPay Preferred: $40 CoPay Non-Preferred: $80 CoPay Subject to Annual Plan Deductible	Generic: $10 CoPay Preferred: $50 CoPay Non-Preferred: $90 CoPay $200 Annual Rx Deductible (T2 & T3)	Generic: $5 CoPay Preferred: $35 CoPay Non-Preferred: $70 CoPay $100 Annual Rx Deductible (T2 & T3)	Generic: $10 CoPay Preferred: $65 CoPay Non-Preferred: $95 CoPay $200 Annual Rx Deductible (T2 & T3)
Mental Health	In-Net: Inpatient or Outpatient: 40% CoIns** NO Out-of-Network	Outpatient: $30 CoPay per visit Inpatient: 30% CoIns** NO Out-of-Network	Outpatient: $20 CoPay per visit Inpatient: $400 CoPay per admission NO Out-of-Network	Outpatient: $30 CoPay per visit Inpatient: 40% CoIns** NO Out-of-Network
Emergency Room	50% Co-Ins After Deductible In & Out of Network	$500 CoPay per visit In & Out of Network	$250 CoPay per visit In & Out of Network	50% CoIns After Deductible In & Out of Network
Dependents	To Age 26	To Age 26	To Age 26	To Age 26
Urgent Care	Subject to Deductible & Co-Ins NO Out-of-Network	$75 CoPay per visit NO Out-of-Network	$50 CoPay per visit NO Out-of-Network	$80 CoPay per visit NO Out-of-Network
Lab and X-rays	Subject to Deductible & CoIns NO Out-of-Network	Lab: 50% CoIns** X-ray/Imaging: 30% CoIns NO Out-of-Network	Lab: $60, X-ray $90 CoPay per svc Imaging: Hospital $100 CoPay per svc, $0 Elsewhere NO Out-of-Network	Lab: 50% CoIns** X-ray/Imaging: 40% CoIns** NO Out-of-Network
Free Standing Outpatient Facility	Subject to Deductible & CoIns NO Out-of-Network	In-Network: 50% CoIns** NO Out-of-Network	$100 CoPay per svc	In-Network: 40% CoIns** NO Out-of-Network
Hospital Based Outpatient Facility	Subject to Deductible & CoIns NO Out-of-Network	In-Network: 30% CoIns** NO Out-of-Network	$300 CoPay per svc	In-Network: 40% CoIns** NO Out-of-Network
Major Diagnostic at Freestanding Facility	Subject to Deductible & CoIns NO Out-of-Network	Lab: 50% CoIns** X-ray/Imaging: 30% CoIns** NO Out-of-Network	Lab: $60, X-ray $90 CoPay per svc Imaging: No Charge NO Out-of-Network	Lab: 50% CoIns** X-ray/Imaging: 40% CoIns** NO Out-of-Network
Major Diagnostic at Hospital	Subject to Deductible & CoIns NO Out-of-Network	Lab: 50% CoIns** X-ray/Imaging: 30% CoIns** NO Out-of-Network	Lab: $60, X-ray $90 CoPay per svc Imaging: $100 CoPay per svc NO Out-of-Network	Lab: 50% CoIns** X-ray/Imaging: 40% CoIns** NO Out-of-Network

* Rates include a $30 for Emp, $50 for Emp+, monthly administrative/billing fee. These rates valid January 1, 2026 through December 31, 2026.

** Co-Insurance % listed is YOUR share of cost. Unless otherwise noted, all Co-Insurance applies after annual deductible is met.

NOTE: This is NOT a comprehensive list of all plan benefits and coverages. See Summary of Benefits and Coverages for each plan, available on request.

I elect Plan #_____ [CIRCLED ABOVE]. My desired start date is _____/01/2026.

My new premium is $_____ and a check in this amount is enclosed.

Please accept this completed form as acknowledgment of my 2025 plan election:

_____ Signature

_____ Date

_____ Print Name

_____ Email Address - Required

_____ Phone Number - Required