Oyster Health US - Medical Plan Comparison

Provided by Vensure

	Comparison Plan		Oyster Health US Plan Options			
	Blue of California Platinum 90 PPO		MVP Silver Plan		MVP ULTRA PLAN*	
Benefit Overview	In-Network	Non-Network	In-Network	Non-Network*	In-Network	Non-Network
Network	Exclusive PPO Network		PHCS/Multiplan		PHCS/Multiplan	
Preventive Care/Wellness Visits	Covered in full. No patient cost	Not Covered	Covered in full. No patient cost	Covered in full. No patient cost	Covered in full. No patient cost	After Deductible, patient pays 60% coinsurance (subject to balance billing)
Office Visits Primary Care/Specialist	PCP: $15/SCP: $30	50% after Deductible	PCP: $15/SCP $25 Limited to 10 visits per plan year	PCP: $15/SCP $25 Limited to 10 visits per plan year	PCP: $20/SCP $40	After Deductible, patient pays 40% coinsurance (subject to balance billing)
Deductible	$0	Individual: $5,000 Family: $10,000	$0	$0	$0	Single $500/Family $1,000
Urgent Care	$15 Copay	50% after Deductible	$35 Copay Limit 3 visits per plan year	$35 Copay Limit 3 visits per plan year	$50 Copay	After Deductible, patient pays 40% coinsurance (subject to balance billing)
Annual Max Out of Pocket	Individual: $3,350 Family: $6,700	Individual: $20,000 Family: $40,000	Single: $5,000 / Family: $10,0000	Single: $5,000 / Family: $10,000	Single $2,000/Family $13,000	No Maximum Out of Pocket
Hospital Inpatient	10% Coinsurance	50% after Deductible	$350 copay per admission Limited to 7 days per plan year	$350 copay per admission Limited to 7 days per plan year	$400 Copay per admission	$400 Copay per admission
Hospital Outpatient	10% Coinsurance	50% after Deductible	$350 copay per visit Limited 2 visits per plan year	$350 copay per visit Limited 2 visits per plan year	$400 Copay per visit	$400 Copay per visit
Emergency Room	$150 Copay per Visit		$350 copay per visit Limited to 1 Visit per plan year	$350 copay per visit Limited to 1 Visit per plan year	$400 Copay per visit	$400 Copay per visit
Non-Hospital based X-Ray/Lab Outpatient Hospital-based not covered	X-Ray - $30 Copay per Visit Lab - $15 Copay per Visit	50% after Deductible	$50 Copay per visit Combined limited 3 visits per plan year	$50 Copay per visit Combined limited 3 visits per plan year	$50 Copay	After Deductible, patient pays 40% coinsurance (subject to balance billing)
Non-Hospital-based CT/MRI/MRA/PET Outpatient Hospital-based not covered	10% Coinsurance	50% after Deductible	$350 copay per visit Limited 2 visits per plan year	$350 copay per visit Limited 2 visits per plan year	$400 Copay per visit	$400 Copay per visit
Prescription Drugs Copays	Tier 1: $5	N/A	Preventive Generic: $0 Copay		Preventive Generic: $0 Copay	
	Tier 2: $15	N/A	Non-Preventive Generic: 20%		Non-Preventive Generic: $10	
	Tier 3: $25	N/A	Preferred Brand: 20%		Preferred Brand: $40	
	Tier 4: 10% up to $250	N/A	Non-Preferred Brand: Not covered		Non-Preferred Brand: $80	
	Specialty: 10% up to $250	N/A	Compounds & Specialty Drugs: NOT COVERED		Compounds & Specialty Drugs: Patient pays 25%	
TeleHealth	N/A		$0 Copay/Unlimited Visits		$0 Copay/Unlimited Visits	
TeleDental	N/A		$0 Copay/Unlimited Visits		$0 Copay/Unlimited Visits	

*No Balance Billing after Copays. Member is not responsible for any amount over copay (in-network where applicable).