

	Oxford Freedom NY P FRDM NG 20/40/100 PPO FAIR 24 CNT (PPO) (UCR=80fh%)		Oxford Freedom NY P FRDM NG 5/15/100 PPO 24 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 20/40/100 PPO 24 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 5/15/100 EPO 24 CNT (EPO) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	5/35/70/100 ded T2-3		5/35/70/100 ded T2-3		5/35/70/100 ded T2-3		5/35/70/100 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A	\$10,000/\$20,000	N/A	\$2,000/\$4,000	N/A	\$3,000/\$6,000	N/A	
Individual/Family OOP Limit	\$3,250/\$6,500	\$25,000/\$50,000 (incl ded)	\$3,750/\$7,500	\$5,500/\$11,000 (incl ded)	\$3,250/\$6,500	\$8,000/\$16,000 (incl ded)	\$3,750/\$7,500	
Co-Insurance	0%	20%	0%	30%	0%	30%	0%	
Office Visits								
Primary Care	\$20	20% after ded	\$5	30% after ded	\$20	30% after ded	\$5	
Specialist	\$40	20% after ded	\$15	30% after ded	\$40	30% after ded	\$15	
Inpatient Services								
Inpatient Hospital	\$400/admit	20% after ded	\$200/admit	30% after ded	\$400/admit	30% after ded	\$200/admit	
Mental Health Inpatient	\$400/admit	20% after ded	\$200/admit	30% after ded	\$400/admit	30% after ded	\$200/admit	
Outpatient Services								
Outpatient Facility	Hosp-\$300; FS-\$100	20% after ded; pre-auth req	Hosp-\$100; FS-\$50	30% after ded; pre-auth req	Hosp-\$300; FS-\$100	30% after ded; pre-auth req	Hosp-\$100; FS-\$50	
Lab/X-Ray	Lab-No charge/\$60 (D/ND); X-ray-\$90	Lab-Not covered; X-ray-20% after ded	Lab-No charge/\$60 (D/ND); X-ray-\$90	Lab-Not covered; X-ray-30% after ded	Lab-No charge/\$60 (D/ND); X-ray-\$90	Lab-Not covered; X-ray-30% after ded	Lab-No charge/\$60 (D/ND); X-ray-\$90	
Mental Health Outpatient	\$20	20% after ded	5	30% after ded	\$20	30% after ded	\$5	
Emergency Care								
Emergency Room	\$250 (waived if admitted)	Paid as in-network	\$250 (waived if admitted)	Paid as in-network	\$250 (waived if admitted)	Paid as in-network	\$250 (waived if admitted)	
Urgent Care	\$50	20% after ded	\$50	30% after ded	\$50	30% after ded	\$50	
Single	2 x \$1,799.90		2 x \$1,535.34		2 x \$1,503.06		2 x \$1,480.39	
EE with Spouse	0 x \$3,599.80		0 x \$3,070.68		0 x \$3,006.12		0 x \$2,960.78	
EE with Child(ren)	0 x \$3,059.83		0 x \$2,610.08		0 x \$2,555.20		0 x \$2,516.66	
Family	0 x \$5,129.72		0 x \$4,375.72		0 x \$4,283.72		0 x \$4,219.11	
Monthly Cost	2 \$3,599.80		2 \$3,070.68		2 \$3,006.12		2 \$2,960.78	
Annual Cost	\$43,197.60		\$36,848.16		\$36,073.44		\$35,529.36	

	Oxford Freedom NY P FRDM NG 20/40/100 EPO 24 CNT (EPO) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/50/100 EPO ZD 24 CNT (EPO) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/40/1500/80 PPO 24 CNT (PPOc) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 50/50/1000/90 EPO 24 CNT (EPOc) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	5/35/70/100 ded T2-3		10/65/95/150 ded T2-3		10/40/80/150 ded T2-3		10/40/80/150 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		N/A		\$1,500/\$3,000	\$4,000/\$8,000	\$1,000/\$2,000	
Individual/Family OOP Limit	\$3,250/\$6,500		\$7,000/\$14,000		\$7,250/\$14,500 (incl ded)	\$10,500/\$21,000 (incl ded)	\$6,700/\$13,400 (incl ded)	
Co-Insurance	0%		0%		20%	40%	10%	
Office Visits								
Primary Care	\$20		\$25		\$25 ded waived	40% after ded	\$50 ded waived	
Specialist	\$40		\$50		\$40 ded waived	40% after ded	\$50 ded waived	
Inpatient Services								
Inpatient Hospital	\$400/admit		\$500/admit		20% after ded	40% after ded	\$250/day after ded; \$2,500 max/admit	
Mental Health Inpatient	\$400/admit		\$500/admit		20% after ded	40% after ded	\$250/day after ded; \$2,500 max/admit	
Outpatient Services								
Outpatient Facility	Hosp-\$300; FS-\$100		Hosp-\$500; FS-\$150		Hosp-\$250 after ded; FS-\$150 after ded	40% after ded; pre-auth req	Hosp-\$250 after ded; FS-\$150 after ded	
Lab/X-Ray	Lab-No charge/\$60 (D/ND); X-ray-\$90		Lab-No charge/\$60 (D/ND); X-ray-\$50		Lab-No charge/50% after ded (D/ND); X-ray-\$25 after ded	Lab-Not covered; X-ray-40% after ded	Lab-No charge/50% after ded (D/ND); X-ray-\$80 after ded	
Mental Health Outpatient	\$20		\$25		\$25 ded waived	40% after ded	\$50 ded waived	
Emergency Care								
Emergency Room	\$250 (waived if admitted)		\$750 (waived if admitted)		\$500 (waived if admitted) ded waived	Paid as in-network	\$500 (waived if admitted) ded waived	
Urgent Care	\$50		\$50		\$75 ded waived	40% after ded	\$75 ded waived	
Single	2 x \$1,451.42		2 x \$1,320.44		2 x \$1,279.70		2 x \$1,242.66	
EE with Spouse	0 x \$2,902.84		0 x \$2,640.88		0 x \$2,559.40		0 x \$2,485.32	
EE with Child(ren)	0 x \$2,467.41		0 x \$2,244.75		0 x \$2,175.49		0 x \$2,112.52	
Family	0 x \$4,136.55		0 x \$3,763.25		0 x \$3,647.15		0 x \$3,541.58	
Monthly Cost	2 \$2,902.84		2 \$2,640.88		2 \$2,559.40		2 \$2,485.32	
Annual Cost	\$34,834.08		\$31,690.56		\$30,712.80		\$29,823.84	

	Oxford Freedom NY G FRDM NG 15/35/1750/90 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/40/1750/80 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 1600/90 PPO HSA 24 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 30/60/2250/70 EPO 24 CNT (EPOc) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	10/40/80/150 ded T2-3		10/40/80/150 ded T2-3		10/40/80 IntDed		10/40/80/150 ded T2-3	
Cost Share Information								
Individual/Family Deductible	\$1,750/\$3,500		\$1,750/\$3,500		\$1,600/\$3,200 (cal yr)	\$4,000/\$8,000 (cal yr)	\$2,250/\$4,500	
Individual/Family OOP Limit	\$8,000/\$16,000 (incl ded)		\$6,500/\$13,000 (incl ded)		\$5,750/\$11,500 (incl ded)	\$10,500/\$21,000 (incl ded)	\$8,250/\$16,500 (incl ded)	
Co-Insurance	10%		20%		10%	40%	30%	
Office Visits								
Primary Care	\$15 ded waived		\$25 ded waived		10% after ded	40% after ded	\$30 ded waived	
Specialist	\$35 ded waived		\$40 ded waived		10% after ded	40% after ded	\$60 ded waived	
Inpatient Services								
Inpatient Hospital	10% after ded		20% after ded		10% after ded	40% after ded	30% after ded	
Mental Health Inpatient	10% after ded		20% after ded		10% after ded	40% after ded	30% after ded	
Outpatient Services								
Outpatient Facility	Hosp-\$300 after ded; FS-\$150 after ded		Hosp-\$250 after ded; FS-\$150 after ded		10% after ded	40% after ded	30% after ded	
Lab/X-Ray	Lab-No charge/50% after ded (D/ND); X-ray-\$80 after ded		Lab-No charge/50% after ded (D/ND); X-ray-\$80 after ded		10% after ded	Lab-Not covered; X-ray-40% after ded	Lab-No charge/50% after ded (D/ND); X-ray-30% after ded	
Mental Health Outpatient	\$15 ded waived		\$25 ded waived		10% after ded	40% after ded	\$30 ded waived	
Emergency Care								
Emergency Room	\$500 (waived if admitted) ded waived		\$500 (waived if admitted) ded waived		50% after ded	Paid as in-network	\$500 (waived if admitted) ded waived	
Urgent Care	\$75 ded waived		\$75 ded waived		10% after ded	40% after ded	\$75 ded waived	
Single	2 x \$1,238.52		2 x \$1,229.16		2 x \$1,186.16		2 x \$1,176.70	
EE with Spouse	0 x \$2,477.04		0 x \$2,458.32		0 x \$2,372.32		0 x \$2,353.40	
EE with Child(ren)	0 x \$2,105.48		0 x \$2,089.57		0 x \$2,016.47		0 x \$2,000.39	
Family	0 x \$3,529.78		0 x \$3,503.11		0 x \$3,380.56		0 x \$3,353.60	
Monthly Cost	2 \$2,477.04		2 \$2,458.32		2 \$2,372.32		2 \$2,353.40	
Annual Cost	\$29,724.48		\$29,499.84		\$28,467.84		\$28,240.80	

	Oxford Freedom NY S FRDM NG 50/100/100 EPO ZD 24 CNT (EPO) (UCR=N/A)		Oxford Freedom NY G FRDM NG 2000/100 EPO HSA PR 24 CNT (HSA) (UCR=N/A)		Oxford Freedom NY G FRDM NG 1600/90 EPO HSA 24 CNT (HSA) (UCR=N/A)		Oxford Freedom NY S FRDM NG 40/80/3250/60 PPO 24 CNT (PPOc) (UCR=140mc%)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	15/65/95/200 ded T2-3		10/40/80 IntDed		10/40/80 IntDed		10/50/90/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		\$2,000/\$4,000		\$1,600/\$3,200		\$3,250/\$6,500	\$6,000/\$12,000
Individual/Family OOP Limit	\$9,450/\$18,900		\$7,050/\$14,100 (incl ded)		\$5,750/\$11,500 (incl ded)		\$9,450/\$18,900 (incl ded)	\$15,500/\$31,000 (incl ded)
Co-Insurance	0%		0%		10%		40%	50%
Office Visits								
Primary Care	\$50		0% after ded		10% after ded		\$40 ded waived	50% after ded
Specialist	\$100		0% after ded		10% after ded		\$80 ded waived	50% after ded
Inpatient Services								
Inpatient Hospital	\$2,800/admit		0% after ded		10% after ded		40% after ded	50% after ded
Mental Health Inpatient	\$2,800/admit		0% after ded		10% after ded		40% after ded	50% after ded
Outpatient Services								
Outpatient Facility	Hosp-\$500; FS-\$250		0% after ded		10% after ded		40% after ded	50% after ded
Lab/X-Ray	Lab-No charge/\$60 (D/ND); X-ray-\$200		0% after ded		10% after ded		Lab-No charge/50% after ded (D/ND); X-ray-40% after ded	Lab-Not covered; X-ray-50% after ded
Mental Health Outpatient	\$50		0% after ded		10% after ded		\$40 ded waived	50% after ded
Emergency Care								
Emergency Room	\$1,500 (waived if admitted)		50% after ded		50% after ded		50% after ded	Paid as in-network
Urgent Care	\$100		0% after ded		10% after ded		\$75 ded waived	50% after ded
Single	2 x \$1,165.55		2 x \$1,143.85		2 x \$1,142.11		2 x \$1,071.73	
EE with Spouse	0 x \$2,331.10		0 x \$2,287.70		0 x \$2,284.22		0 x \$2,143.46	
EE with Child(ren)	0 x \$1,981.44		0 x \$1,944.55		0 x \$1,941.59		0 x \$1,821.94	
Family	0 x \$3,321.82		0 x \$3,259.97		0 x \$3,255.01		0 x \$3,054.43	
Monthly Cost	2 \$2,331.10		2 \$2,287.70		2 \$2,284.22		2 \$2,143.46	
Annual Cost	\$27,973.20		\$27,452.40		\$27,410.64		\$25,721.52	

	Oxford Freedom NY S FRDM NG 30/60/2250/70 PPO HSA 24 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY S FRDM NG 40/80/3250/60 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY S FRDM NG 30/60/3000/80 EPO HSA 24 CNT (HSA) (UCR=N/A)		Oxford Freedom NY S FRDM NG 2500/60 EPO HSA 24 CNT (HSA) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	10/40/80 IntDed		10/50/90/200 ded T2-3		10/40/80 IntDed		10/40/80 IntDed	
Cost Share Information								
Individual/Family Deductible	\$2,250/\$4,500	\$6,000/\$12,000	\$3,250/\$6,500		\$3,000/\$6,000		\$2,500/\$5,000	
Individual/Family OOP Limit	\$8,000/\$16,000 (incl ded)	\$15,500/\$31,000 (incl ded)	\$9,450/\$18,900 (incl ded)		\$7,150/\$14,300 (incl ded)		\$8,000/\$16,000 (incl ded)	
Co-Insurance	30%	50%	40%		20%		40%	
Office Visits								
Primary Care	\$30 after ded	50% after ded	\$40 ded waived		\$30 after ded		40% after ded	
Specialist	\$60 after ded	50% after ded	\$80 ded waived		\$60 after ded		40% after ded	
Inpatient Services								
Inpatient Hospital	30% after ded	50% after ded	40% after ded		20% after ded		40% after ded	
Mental Health Inpatient	30% after ded	50% after ded	40% after ded		20% after ded		40% after ded	
Outpatient Services								
Outpatient Facility	Hosp-\$250 after ded; FS-\$150 after ded	50% after ded; pre-auth req	40% after ded		Hosp-\$250 after ded; FS-\$150 after ded		40% after ded	
Lab/X-Ray	30% after ded	Lab-Not covered; X-ray-50% after ded	Lab-No charge/50% after ded (D/ND); X-ray-40% after ded		Lab-20% after ded; X-ray-\$90 after ded		40% after ded	
Mental Health Outpatient	\$30 after ded	50% after ded	\$40 ded waived		\$30 after ded		40% after ded	
Emergency Care								
Emergency Room	50% after ded	Paid as in-network	50% after ded		\$500 (waived if admitted) after ded		50% after ded	
Urgent Care	\$75 after ded	50% after ded	\$75 ded waived		\$75 after ded		40% after ded	
Single	2 x \$1,040.60		2 x \$1,032.07		2 x \$1,002.75		2 x \$971.02	
EE with Spouse	0 x \$2,081.20		0 x \$2,064.14		0 x \$2,005.50		0 x \$1,942.04	
EE with Child(ren)	0 x \$1,769.02		0 x \$1,754.52		0 x \$1,704.68		0 x \$1,650.73	
Family	0 x \$2,965.71		0 x \$2,941.40		0 x \$2,857.84		0 x \$2,767.41	
Monthly Cost	2 \$2,081.20		2 \$2,064.14		2 \$2,005.50		2 \$1,942.04	
Annual Cost	\$24,974.40		\$24,769.68		\$24,066.00		\$23,304.48	

Prepared For: **Oxford 2024 3rd qtr Freedom Mid Hudson**

Orange County, NY 10910

Prepared By: Clifford Grekin Inc. - (631)963-6020

Health Plan Comparison Report (4L)

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SIC: 0000

Oxford Freedom NY B FRDM NG 5000/50 EPO HSA 24 CNT (HSA) (UCR=N/A)		
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/40/80 IntDed	
Cost Share Information		
Individual/Family Deductible	\$5,000/\$10,000	
Individual/Family OOP Limit	\$8,000/\$16,000 (incl ded)	
Co-Insurance	50%	
Office Visits		
Primary Care	50% after ded	
Specialist	50% after ded	
Inpatient Services		
Inpatient Hospital	50% after ded	
Mental Health Inpatient	50% after ded	
Outpatient Services		
Outpatient Facility	50% after ded	
Lab/X-Ray	50% after ded	
Mental Health Outpatient	50% after ded	
Emergency Care		
Emergency Room	50% after ded	
Urgent Care	50% after ded	
Single	2 x	\$904.74
EE with Spouse	0 x	\$1,809.48
EE with Child(ren)	0 x	\$1,538.06
Family	0 x	\$2,578.51
Monthly Cost	2	\$1,809.48
Annual Cost		\$21,713.76

The rates and benefits in this report are for discussion and estimation purposes only and are not valid without approval from the insurance carriers. Final rates must be based on insurance carrier confirmation and final enrollment. Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible