Prepared For: **Oxford 2025 1st qtr Freedom New York City**

New York County, NY 10001

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

Health Plan Comparison Report (4L)

Effective Date: 01/01/2025 Prepared On: 11/01/2024

Report ID: 39158756 SIC: 0000

	Oxford Freedom NY P FRDM NG 20/40/100 PPO FAIR 25 CNT (PPO) (UCR=80fh%)		Oxford Freedom NY P FRDM NG 5/15/100 PPO 25 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 20/40/100 PPO 25 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 5/15/100 EPO 25 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	$300	20% after ded; pre-auth req	$100	30% after ded; pre-auth req	$300	30% after ded; pre-auth req	$100	
Lab/X-Ray	Lab-$60; X-ray-$90	Lab-Not covered; X-ray-20% after ded	Lab-$60; X-ray-$90	Lab-Not covered; X-ray-30% after ded	Lab-$60; X-ray-$90	Lab-Not covered; X-ray-30% after ded	Lab-$60; X-ray-$90	
Mental Health Outpatient	$40	20% after ded	$15	30% after ded	$40	30% after ded	$15	
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 $1,906.84		2 x $1,597.89		2 x $1,566.10		2 x $1,542.38	
EE with Spouse	0 x $3,813.67		0 x $3,195.77		0 x $3,132.19		0 x $3,084.76	
EE with Child(ren)	0 x $3,241.62		0 x $2,716.40		0 x $2,662.36		0 x $2,622.05	
Family	0 x $5,434.49		0 x $4,553.97		0 x $4,463.37		0 x $4,395.79	
Monthly Cost	2 $3,813.68		2 $3,195.78		2 $3,132.20		2 $3,084.76	
Annual Cost	$45,764.16		$38,349.36		$37,586.40		$37,017.12	

 Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible

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	Oxford Freedom NY P FRDM NG 15/25/100 EPO 25 CNT (EPO) (UCR=N/A)		Oxford Freedom NY P FRDM NG 20/40/100 EPO 25 CNT (EPO) (UCR=N/A)		Oxford Freedom NY P FRDM NG 10/25/250/90 EPO 25 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/50/100 EPO ZD 25 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	10/65/95/150 ded T2-3		5/35/70/100 ded T2-3		5/35/70/100 ded T2-3		10/65/95/150 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		N/A		$250/$500		N/A	
Individual/Family OOP Limit	$3,500/$7,000		$3,250/$6,500		$2,750/$5,500 (incl ded)		$7,000/$14,000	
Co-Insurance	0%		0%		10%		0%	
Office Visits								
Primary Care	$15		$20		$10 ded waived		$25	
Specialist	$25		$40		$25 ded waived		$50	
Inpatient Services								
Inpatient Hospital	$200/day; $800 max/admit		$400/admit		10% after ded		$500/admit	
Mental Health Inpatient	$200/day; $800 max/admit $200/day; $800 max/admit		$400/admit		10% after ded		$500/admit	
Outpatient Services								
Outpatient Facility	$100		$300		10% after ded		$250	
Lab/X-Ray	Lab-$60; X-ray-$200		Lab-$60; X-ray-$90		Lab-50% after ded; X-ray-10% after ded		Lab-$60; X-ray-$50	
Mental Health Outpatient	$25		$40		$25 ded waived		$50	
Emergency Care								
Emergency Room	$250 (waived if admitted)		$250 (waived if admitted)		50% after ded		$750 (waived if admitted)	
Urgent Care	$50		$50		$50 ded waived		$75	
Single	2 x $1,517.81		2 x $1,513.85		2 x $1,465.17		2 x $1,374.66	
EE with Spouse	0 x $3,035.63		0 x $3,027.69		0 x $2,930.34		0 x $2,749.32	
EE with Child(ren)	0 x $2,580.29		0 x $2,573.54		0 x $2,490.79		0 x $2,336.92	
Family	0 x $4,325.76		0 x $4,314.46		0 x $4,175.74		0 x $3,917.78	
Monthly Cost	2 $3,035.62		2 $3,027.70		2 $2,930.34		2 $2,749.32	
Annual Cost	$36,427.44		$36,332.40		$35,164.08		$32,991.84	

 Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible

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	Oxford Freedom NY G FRDM NG 25/40/1500/80 PPO 25 CNT (PPOc) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 50/50/1000/90 EPO 25 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 15/35/1750/90 EPO 25 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/40/1750/80 EPO 25 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		10/40/80/150 ded T2-3		10/40/80/150 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$1,500/$3,000	$4,000/$8,000	$1,000/$2,000		$1,750/$3,500		$1,750/$3,500	
Individual/Family OOP Limit	$7,250/$14,500 (incl ded)	$10,500/$21,000 (incl ded)	$6,700/$13,400 (incl ded)		$8,000/$16,000 (incl ded)		$6,500/$13,000 (incl ded)	
Co-Insurance	20%	40%	10%		10%		20%	
Office Visits								
Primary Care	$25 ded waived	40% after ded	$50 ded waived		$15 ded waived		$25 ded waived	
Specialist	$40 ded waived	40% after ded	$50 ded waived		$35 ded waived		$40 ded waived	
Inpatient Services								
Inpatient Hospital	20% after ded	40% after ded	$250/day after ded		10% after ded		20% after ded	
Mental Health Inpatient	20% after ded	40% after ded	$250/day after ded		10% after ded		20% after ded	
Outpatient Services								
Outpatient Facility	$150 after ded	40% after ded; pre-auth req	$150 after ded		$150 after ded		$150 after ded	
Lab/X-Ray	Lab-50% after ded; X-ray-$25 after ded	Lab-Not covered; X-ray-40% after ded	Lab-50% after ded; X-ray-$80 after ded		Lab-50% after ded; X-ray-$80 after ded		Lab-50% after ded; X-ray-$80 after ded	
Mental Health Outpatient	$40 ded waived	40% after ded	$50 ded waived		$35 ded waived		$40 ded waived	
Emergency Care								
Emergency Room	$500 (waived if admitted) ded waived	Paid as in-network	$500 (waived if admitted) ded waived		$500 (waived if admitted) ded waived		$500 (waived if admitted) ded waived	
Urgent Care	$75 ded waived	40% after ded	$75 ded waived		$75 ded waived		$75 ded waived	
Single	2 x $1,336.18		2 x $1,299.73		2 x $1,289.37		2 x $1,283.00	
EE with Spouse	0 x $2,672.37		0 x $2,599.46		0 x $2,578.74		0 x $2,565.99	
EE with Child(ren)	0 x $2,271.51		0 x $2,209.55		0 x $2,191.93		0 x $2,181.10	
Family	0 x $3,808.12		0 x $3,704.23		0 x $3,674.71		0 x $3,656.54	
Monthly Cost	2 $2,672.36		2 $2,599.46		2 $2,578.74		2 $2,566.00	
Annual Cost	$32,068.32		$31,193.52		$30,944.88		$30,792.00	

 Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible

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New York County, NY 10001 — Effective Date: 01/01/2025 — Prepared On: 11/01/2024

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	Oxford Freedom NY G FRDM NG 1650/90 PPO HSA 25 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 30/60/2250/70 EPO 25 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 2000/100 EPO HSA PR 25 CNT (HSA) (UCR=N/A)		Oxford Freedom NY G FRDM NG 1650/90 EPO HSA 25 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		10/40/80/150 ded T2-3		10/40/80 IntDed		10/40/80 IntDed	
Cost Share Information								
Individual/Family Deductible	$1,650/$3,300	$4,000/$8,000	$2,250/$4,500		$2,000/$4,000		$1,650/$3,300	
Individual/Family OOP Limit	$5,750/$11,500 (incl ded)	$10,500/$21,000 (incl ded)	$7,250/$14,500 (incl ded)		$7,050/$14,100 (incl ded)		$5,750/$11,500 (incl ded)	
Co-Insurance	10%	40%	30%		0%		10%	
Office Visits								
Primary Care	10% after ded	40% after ded	$30 ded waived		0% after ded		10% after ded	
Specialist	10% after ded	40% after ded	$60 ded waived		0% after ded		10% after ded	
Inpatient Services								
Inpatient Hospital	10% after ded	40% after ded	30% after ded		0% after ded		10% after ded	
Mental Health Inpatient	10% after ded	40% after ded	30% after ded		0% after ded		10% after ded	
Outpatient Services								
Outpatient Facility	10% after ded	40% after ded	30% after ded		0% after ded		10% after ded	
Lab/X-Ray	10% after ded	Lab-Not covered; X-ray-40% after ded	Lab-50% after ded; X-ray-30% after ded		0% after ded		10% after ded	
Mental Health Outpatient	10% after ded	40% after ded	$60 ded waived		0% after ded		10% after ded	
Emergency Care								
Emergency Room	50% after ded	Paid as in-network	$500 (waived if admitted) ded waived		50% after ded		50% after ded	
Urgent Care	10% after ded	40% after ded	$75 ded waived		0% after ded		10% after ded	
Single	2 x $1,270.71		2 x $1,238.15		2 x $1,229.96		2 x $1,225.47	
EE with Spouse	0 x $2,541.43		0 x $2,476.29		0 x $2,459.93		0 x $2,450.94	
EE with Child(ren)	0 x $2,160.21		0 x $2,104.85		0 x $2,090.93		0 x $2,083.30	
Family	0 x $3,621.53		0 x $3,528.72		0 x $3,505.40		0 x $3,492.59	
Monthly Cost	2 $2,541.42		2 $2,476.30		2 $2,459.92		2 $2,450.94	
Annual Cost	$30,497.04		$29,715.60		$29,519.04		$29,411.28	

 Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible

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	Oxford Freedom NY S FRDM NG 50/100/100 EPO ZD 25 CNT (EPO) (UCR=N/A)		Oxford Freedom NY S FRDM NG 40/80/3250/60 PPO 25 CNT (PPOc) (UCR=140mc%)		Oxford Freedom NY S FRDM NG 30/60/2250/70 PPO HSA 25 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY S FRDM NG 40/80/3250/60 EPO 25 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	15/65/95/200 ded T2-3		10/50/90/200 ded T2-3		10/40/80 IntDed		10/50/90/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		$3,250/$6,500	$6,000/$12,000	$2,250/$4,500	$6,000/$12,000	$3,250/$6,500	
Individual/Family OOP Limit	$9,200/$18,400		$9,200/$18,400 (incl ded)	$15,500/$31,000 (incl ded)	$8,000/$16,000 (incl ded)	$15,500/$31,000 (incl ded)	$9,200/$18,400 (incl ded)	
Co-Insurance	0%		40%	50%	30%	50%	40%	
Office Visits								
Primary Care	$50		$40 ded waived	50% after ded	$30 after ded	50% after ded	$40 ded waived	
Specialist	$100		$80 ded waived	50% after ded	$60 after ded	50% after ded	$80 ded waived	
Inpatient Services								
Inpatient Hospital	$1,500/admit		40% after ded	50% after ded	30% after ded	50% after ded	40% after ded	
Mental Health Inpatient	$1,500/admit		40% after ded	50% after ded	30% after ded	50% after ded	40% after ded	
Outpatient Services								
Outpatient Facility	$250		40% after ded	50% after ded	$150 after ded	50% after ded; pre-auth req	40% after ded	
Lab/X-Ray	Lab-$60; X-ray-$200		Lab-50% after ded; X-ray-40% after ded	Lab-Not covered; X-ray-50% after ded	30% after ded	Lab-Not covered; X-ray-50% after ded	Lab-50% after ded; X-ray-40% after ded	
Mental Health Outpatient	$100		$80 ded waived	50% after ded	$60 after ded	50% after ded	$80 ded waived	
Emergency Care								
Emergency Room	$1,500 (waived if admitted)		50% after ded	Paid as in-network	50% after ded	Paid as in-network	50% after ded	
Urgent Care	$100		$100 ded waived	50% after ded	$100 after ded	50% after ded	$100 ded waived	
Single	2 x $1,224.03		2 x $1,129.81		2 x $1,122.64		2 x $1,089.46	
EE with Spouse	0 x $2,448.05		0 x $2,259.63		0 x $2,245.28		0 x $2,178.91	
EE with Child(ren)	0 x $2,080.84		0 x $1,920.69		0 x $1,908.49		0 x $1,852.08	
Family	0 x $3,488.48		0 x $3,219.97		0 x $3,199.52		0 x $3,104.96	
Monthly Cost	2 $2,448.06		2 $2,259.62		2 $2,245.28		2 $2,178.92	
Annual Cost	$29,376.72		$27,115.44		$26,943.36		$26,147.04	

 Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible

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	Oxford Freedom NY S FRDM NG 30/60/3000/80 EPO HSA 25 CNT (HSA) (UCR=N/A)		Oxford Freedom NY S FRDM NG 2500/60 EPO HSA 25 CNT (HSA) (UCR=N/A)		Oxford Freedom NY B FRDM NG 30/60/6750/80 PPO HSA 25 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY B FRDM NG 5000/50 EPO HSA 25 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		10/40/80 IntDed		10/50/90 IntDed		10/40/80 IntDed	
Cost Share Information								
Individual/Family Deductible	$3,000/$6,000		$2,500/$5,000		$6,750/$13,500	$12,500/$25,000	$5,000/$10,000	
Individual/Family OOP Limit	$7,150/$14,300 (incl ded)		$8,000/$16,000 (incl ded)		$8,000/$16,000 (incl ded)	$31,250/$62,500 (incl ded)	$8,000/$16,000 (incl ded)	
Co-Insurance	20%		40%		20%	20%	50%	
Office Visits								
Primary Care	$30 after ded		40% after ded		$30 after ded	20% after ded	50% after ded	
Specialist	$60 after ded		40% after ded		$60 after ded	20% after ded	50% after ded	
Inpatient Services								
Inpatient Hospital	20% after ded		40% after ded		20% after ded	20% after ded	50% after ded	
Mental Health Inpatient	20% after ded		40% after ded		20% after ded	20% after ded	50% after ded	
Outpatient Services								
Outpatient Facility	$250 after ded		40% after ded		20% after ded	20% after ded; pre-auth req	50% after ded	
Lab/X-Ray	Lab-20% after ded; X-ray-$90 after ded		40% after ded		20% after ded	Lab-Not covered; X-ray-20% after ded	50% after ded	
Mental Health Outpatient	$60 after ded		40% after ded		$60 after ded	20% after ded	50% after ded	
Emergency Care								
Emergency Room	$500 (waived if admitted) after ded		50% after ded		50% after ded	Paid as in-network	50% after ded	
Urgent Care	$100 after ded		40% after ded		20% after ded	20% after ded	50% after ded	
Single	2 x $1,085.72		2 x $1,051.89		2 x $1,005.94		2 x $984.14	
EE with Spouse	0 x $2,171.44		0 x $2,103.78		0 x $2,011.89		0 x $1,968.28	
EE with Child(ren)	0 x $1,845.72		0 x $1,788.22		0 x $1,710.10		0 x $1,673.04	
Family	0 x $3,094.31		0 x $2,997.89		0 x $2,866.94		0 x $2,804.79	
Monthly Cost	2 $2,171.44		2 $2,103.78		2 $2,011.88		2 $1,968.28	
Annual Cost	$26,057.28		$25,245.36		$24,142.56		$23,619.36	

 Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible