Prepared For : Oxford 2016 2nd qtr Liberty
New York County, NY 10001

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

Health Plan Comparison Report (4L)

Prepared On : 2/2/2016 Report Id : 30340627

Effective Date : 04/01/2016 SIC : 0000

	Oxford Liberty L Platinum HMO 20/40 Gated OHP CNT* (HMO) (UCR=N/A)	Oxford Liberty L Gold HMO 30/60 Gated OHP CNT* (HMOc) (UCR=N/A)	Oxford Liberty L Gold EPO 15/30 Non-Gated OHI CNT (EPOc) (UCR=N/A)		Oxford Liberty L Gold EPO 25/40 Non-Gated OHI CNT (EPOc) (UCR=N/A)	
	In-Network	**In-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs						
Drug Card	10/30/60/100 ded T2-3	15/35/75/100 ded T2-3	10/35/75/100 ded T2-3		10/35/75/100 ded T2-3	
Cost Share Information						
Individual/Family Deductible	N/A	$1,000/$2,000	$800/$1,600		$1,250/$2,500	
Individual/Family OOP Limit	$3,000/$6,000	$4,000/$8,000 (incl ded)	$4,000/$8,000 (incl ded)		$5,000/$10,000 (incl ded)	
Co-Insurance	N/A	N/A	10%		20%	
Office Visits						
Primary Care	$20	$30 ded waived	$15 ded waived		$25 ded waived	
Specialist	$40	$60 ded waived	$30 ded waived		$40 ded waived	
Inpatient Services						
Inpatient Hospital	$500/day; $1,000 max/admit	$500/day after ded; $2,000 max/admit	10% after ded		20% after ded	
Mental Health Inpatient	$500/day; $1,000 max/admit	$500/day after ded; $2,000 max/admit	10% after ded		20% after ded	
Outpatient Services						
Outpatient Facility	Hosp-$250 FS-$150	Hosp-$250 after ded FS-$150 after ded	Hosp-$250 after ded FS-$150 after ded		Hosp-$250 after ded FS-$150 after ded	
Lab/X-Ray	Lab-No charge; X-ray-$35; $500 max/contr yr	Lab-No charge; X-ray-$35 ded waived; $500 max/contr yr	Lab-No charge; X-ray-$90 ded waived		Lab-No charge; X-ray-$90 ded waived	
Mental Health Outpatient	$40	$60 ded waived	$30 ded waived		$40 ded waived	
Emergency Care						
Emergency Room	$150 (waived if admitted)	$200 (waived if admitted) ded waived	$300 (waived if admitted) ded waived		$300 (waived if admitted) ded waived	
Urgent Care	$50	$75 ded waived	$75 ded waived		$75 ded waived	
Single	1 x $847.21	1 x $739.80	1 x $782.06		1 x $750.40	
EE with Spouse	0 x $1,694.42	0 x $1,479.61	0 x $1,564.11		0 x $1,500.80	
EE with Child(ren)	0 x $1,440.26	0 x $1,257.66	0 x $1,329.50		0 x $1,275.69	
Family	1 x $2,414.55	1 x $2,108.44	1 x $2,228.86		1 x $2,138.64	
Monthly Cost	2 $3,261.76	2 $2,848.24	2 $3,010.92		2 $2,889.04	
Annual Cost	$39,141.12	$34,178.88	$36,131.04		$34,668.48	

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	Oxford Liberty L Gold EPO 30/60 Gated OHI CNT (EPOc) (UCR=N/A)		Oxford Liberty L Silver EPO 40/70 Non-Gated OHI CNT (EPOc) (UCR=N/A)		Oxford Liberty L Silver EPO Prim Adv $1500 Non-Gated OHI CNT (EPOc) (UCR=N/A)		Oxford Liberty L Silver EPO 25/50 Gated OHI 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	15/35/75/100 ded T2-3		15/45/75/100 ded T2-3		15/35/75 IntDed T2-3		15/65/85/100 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$1,000/$2,000		$2,000/$4,000		$1,500/$3,000		$2,000/$4,000	
Individual/Family OOP Limit	$4,000/$8,000 (incl ded)		$6,600/$13,200 (incl ded)		$5,500/$11,000 (incl ded)		$6,600/$13,200 (incl ded)	
Co-Insurance	N/A		30%		30%		30%	
Office Visits								
Primary Care	$30 ded waived		$40 ded waived		$25 ded waived		$25 ded waived	
Specialist	$60 ded waived		$70 ded waived		$50 after ded		$50 ded waived	
Inpatient Services								
Inpatient Hospital	$500/day after ded; $2,000 max/admit		30% after ded		$250/day after ded; $1,250 max/admit		30% after ded	
Mental Health Inpatient	$500/day after ded; $2,000 max/admit		30% after ded		$250/day after ded; $1,250 max/admit		30% after ded	
Outpatient Services								
Outpatient Facility	Hosp-$250 after ded FS-$150 after ded		30% after ded		Hosp-$250 after ded FS-$150 after ded		30% after ded	
Lab/X-Ray	Lab-No charge; X-ray-$35 ded waived; $500 max/contr yr		Lab-No charge; X-ray-30% after ded		Lab-$50 after ded; X-ray-$90 after ded		Lab-No charge; X-ray-30% after ded	
Mental Health Outpatient	$60 ded waived		$70 ded waived		$25 after ded		$50 ded waived	
Emergency Care								
Emergency Room	$200 (waived if admitted) ded waived		$500 (waived if admitted) ded waived		$100 (waived if admitted) after ded		$500 (waived if admitted) ded waived	
Urgent Care	$75 ded waived		$75 ded waived		$75 after ded		$80 ded waived	
Single	1 x $747.27		1 x $654.16		1 x $651.27		1 x $635.34	
EE with Spouse	0 x $1,494.55		0 x $1,308.32		0 x $1,302.55		0 x $1,270.68	
EE with Child(ren)	0 x $1,270.37		0 x $1,112.07		0 x $1,107.17		0 x $1,080.08	
Family	1 x $2,129.73		1 x $1,864.35		1 x $1,856.13		1 x $1,810.71	
Monthly Cost	2 $2,877.00		2 $2,518.51		2 $2,507.40		2 $2,446.05	
Annual Cost	$34,524.00		$30,222.12		$30,088.80		$29,352.60	

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	Oxford Liberty L Silver EPO 30/75 Non-Gated OHI CNT (EPOc) (UCR=N/A)		**Oxford Liberty L Silver EPO HSA $2000 25/50 Non-Gated OHI CNT (HSA) (UCR=N/A)**		**Oxford Liberty L Bronze PPO HSA $5000 30/60 Non-Gated OHI Fair CNT (HSA) (UCR=80fh%)**		**Oxford Liberty L Bronze PPO HSA $5000 30/60 Non-Gated OHI MNRP CNT (HSA) (UCR=140mc%)**	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs								
Drug Card	15/65/50%to$800/100 ded T2-3		15/35/75 IntDed		15/35/75 IntDed		15/35/75 IntDed	
Cost Share Information								
Individual/Family Deductible	$3,000/$6,000		$2,000/$4,000		$5,000/$10,000	$10,000/$20,000	$5,000/$10,000	$10,000/$20,000
Individual/Family OOP Limit	$6,600/$13,200 (incl ded)		$4,500/$9,000 (incl ded)		$6,450/$12,900 (incl ded)	$25,000/$50,000 (incl ded)	$6,450/$12,900 (incl ded)	$25,000/$50,000 (incl ded)
Co-Insurance	40%		20%		20%	20%	20%	20%
Office Visits								
Primary Care	$30 ded waived		$25 after ded		$30 after ded	20% after ded	$30 after ded	20% after ded
Specialist	$75 ded waived		$50 after ded		$60 after ded	20% after ded	$60 after ded	20% after ded
Inpatient Services								
Inpatient Hospital	40% after ded		20% after ded		20% after ded	20% after ded	20% after ded	20% after ded
Mental Health Inpatient	40% after ded		20% after ded		20% after ded	20% after ded	20% after ded	20% after ded
Outpatient Services								
Outpatient Facility	40% after ded		Hosp-$250 after ded FS-$150 after ded		20% after ded	20% after ded	20% after ded	20% after ded
Lab/X-Ray	Lab-No charge; X-ray-40% after ded		Lab-20% after ded; X-ray-$90 after ded		20% after ded	20% after ded	20% after ded	20% after ded
Mental Health Outpatient	$75 ded waived		$50 after ded		$60 after ded	20% after ded	$60 after ded	20% after ded
Emergency Care								
Emergency Room	$500 (waived if admitted) after ded		$250 (waived if admitted) after ded		20% after ded	Paid as in-network	20% after ded	Paid as in-network
Urgent Care	$80 ded waived		$75 after ded		20% after ded	20% after ded	20% after ded	20% after ded
Single	1 x $615.78		1 x $634.38		1 x $580.69		1 x $546.45	
EE with Spouse	0 x $1,231.55		0 x $1,268.76		0 x $1,161.38		0 x $1,092.91	
EE with Child(ren)	0 x $1,046.82		0 x $1,078.44		0 x $987.17		0 x $928.97	
Family	1 x $1,754.97		1 x $1,807.99		1 x $1,654.97		1 x $1,557.39	
Monthly Cost	2 $2,370.75		2 $2,442.37		2 $2,235.66		2 $2,103.84	
Annual Cost	$28,449.00		$29,308.44		$26,827.92		$25,246.08	

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	Oxford Liberty L Bronze EPO HSA $5000 Non-Gated OHI 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	$6,350/$12,700 (incl ded)	
Co-Insurance	20%	
Office Visits		
Primary Care	20% after ded	
Specialist	20% after ded	
Inpatient Services		
Inpatient Hospital	20% after ded	
Mental Health Inpatient	20% after ded	
Outpatient Services		
Outpatient Facility	20% after ded	
Lab/X-Ray	20% after ded	
Mental Health Outpatient	20% after ded	
Emergency Care		
Emergency Room	20% after ded	
Urgent Care	20% after ded	
Single	1 x $501.97	
EE with Spouse	0 x $1,003.94	
EE with Child(ren)	0 x $853.35	
Family	1 x $1,430.62	
Monthly Cost	2 $1,932.59	
Annual Cost	$23,191.08	