

	Oxford Freedom F Platinum PPO 20/40 Non-Gated OHI FAIR CNT		Oxford Freedom F Platinum PPO 5/15 Non-Gated OHI CNT		Oxford Freedom F Platinum PPO 20/40 Non-Gated OHI CNT		Oxford Freedom F Platinum EPO 5/15 Non-Gated OHI CNT	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	5/30/60/100 ded T2-3		5/30/60/100 ded T2-3		5/30/60/100 ded T2-3		5/30/60/100 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A	\$3,000/\$6,000	N/A	\$2,000/\$4,000	N/A	\$3,000/\$6,000	N/A	
Individual/Family OOP Limit	\$3,000/\$6,000	\$7,500/\$15,000 (incl ded)	\$3,000/\$6,000	\$5,000/\$10,000 (incl ded)	\$3,000/\$6,000	\$7,500/\$15,000 (incl ded)	\$3,000/\$6,000	
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	\$500/admit; pre-auth req	20% after ded; pre-auth req	\$200/admit; pre-auth req	30% after ded; pre-auth req	\$500/admit; pre-auth req	30% after ded; pre-auth req	\$200/admit	
Mental Health Inpatient	\$500/admit; pre-auth req	20% after ded; pre-auth req	\$200/admit; pre-auth req	30% after ded; pre-auth req	\$500/admit; pre-auth req	30% after ded; pre-auth req	\$200/admit	
Outpatient Services								
Outpatient Facility	Hosp-\$300; FS-\$100; pre-auth req	20% after ded; pre-auth req	Hosp-\$100; FS-\$50; pre-auth req	30% after ded; pre-auth req	Hosp-\$300; FS-\$100; pre-auth req	30% after ded; pre-auth req	Hosp-\$100; FS-\$50	
Lab/X-Ray	Lab-No charge; X-ray-\$90	20% after ded	Lab-No charge; X-ray-\$90	30% after ded	Lab-No charge; X-ray-\$90	30% after ded	Lab-No charge; X-ray-\$90	
Mental Health Outpatient	\$40	20% after ded	\$15	30% after ded	\$40	30% after ded	\$15	
Emergency Care								
Emergency Room	\$200 (waived if admitted)	Paid as in-network	\$200 (waived if admitted)	Paid as in-network	\$200 (waived if admitted)	Paid as in-network	\$200 (waived if admitted)	
Urgent Care	\$50	20% after ded	\$50	30% after ded	\$50	30% after ded	\$50	
Single	1 x	\$1,207.79	1 x	\$1,073.79	1 x	\$1,050.31	1 x	\$1,003.51
EE with Spouse	0 x	\$2,415.58	0 x	\$2,147.58	0 x	\$2,100.62	0 x	\$2,007.02
EE with Child(ren)	0 x	\$2,053.24	0 x	\$1,825.44	0 x	\$1,785.53	0 x	\$1,705.97
Family	1 x	\$3,442.20	1 x	\$3,060.30	1 x	\$2,993.38	1 x	\$2,860.00
Monthly Cost	2	\$4,649.99	2	\$4,134.09	2	\$4,043.69	2	\$3,863.51
Annual Cost		\$55,799.88		\$49,609.08		\$48,524.28		\$46,362.12

	Oxford Freedom F Platinum EPO 20/40 Non-Gated OHI CNT		Oxford Freedom F Gold PPO 25/40 Non-Gated OHI CNT		Oxford Freedom F Gold EPO 15/30 Non-Gated OHI CNT		Oxford Freedom F Gold EPO \$50 Non-Gated OHI CNT	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	5/30/60/100 ded T2-3		10/35/75/100 ded T2-3		15/35/75/100 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		\$750/\$1,500	
Individual/Family OOP Limit	\$3,000/\$6,000		\$4,000/\$8,000 (incl ded)		\$4,000/\$8,000 (incl ded)		\$4,000/\$8,000 (incl ded)	
Co-Insurance	0%		20%		10%		10%	
Office Visits								
Primary Care	\$20		\$25 ded waived		\$15 ded waived		\$50 ded waived	
Specialist	\$40		\$40 ded waived		\$30 ded waived		\$50 ded waived	
Inpatient Services								
Inpatient Hospital	\$500/admit		20% after ded; pre-auth req		10% after ded		\$250/day after ded; \$2,500 max/contr yr	
Mental Health Inpatient	\$500/admit		20% after ded; pre-auth req		10% after ded		\$250/day after ded; \$2,500 max/contr yr	
Outpatient Services								
Outpatient Facility	Hosp-\$300; FS-\$100		Hosp-\$250 after ded; FS-\$150 after ded; pre-auth req		Hosp-\$300 after ded; FS-\$150 after ded		Hosp-\$250 after ded; FS-\$150 after ded	
Lab/X-Ray	Lab-No charge; X-ray-\$90		Lab-No charge; X-ray-\$25 after ded		Lab-No charge; X-ray-\$80 after ded		Lab-No charge; X-ray-\$80 after ded	
Mental Health Outpatient	\$40		\$40 ded waived		\$30 ded waived		\$50 ded waived	
Emergency Care								
Emergency Room	\$200 (waived if admitted)		\$300 (waived if admitted) ded waived		\$400 (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	\$984.22	1 x	\$911.46	1 x	\$861.49	1 x	\$853.94
EE with Spouse	0 x	\$1,968.44	0 x	\$1,822.92	0 x	\$1,722.98	0 x	\$1,707.88
EE with Child(ren)	0 x	\$1,673.17	0 x	\$1,549.48	0 x	\$1,464.53	0 x	\$1,451.70
Family	1 x	\$2,805.03	1 x	\$2,597.66	1 x	\$2,455.25	1 x	\$2,433.73
Monthly Cost	2	\$3,789.25	2	\$3,509.12	2	\$3,316.74	2	\$3,287.67
Annual Cost		\$45,471.00		\$42,109.44		\$39,800.88		\$39,452.04

	Oxford Freedom F Gold EPO 25/40 Non-Gated OHI CNT		Oxford Freedom F Silver PPO 40/70 Non-Gated OHI CNT		Oxford Freedom F Silver EPO 40/70 Non-Gated OHI CNT		Oxford Freedom F Gold PPO HSA \$1500 Non-Gated OHI CNT	
	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		15/45/75/100 ded T2-3		10/35/75 IntDed	
Cost Share Information								
Individual/Family Deductible	\$1,250/\$2,500		\$2,500/\$5,000		\$2,500/\$5,000		\$1,500/\$3,000	
Individual/Family OOP Limit	\$5,000/\$10,000 (incl ded)		\$6,850/\$13,700 (incl ded)		\$10,000/\$20,000 (incl ded)		\$4,000/\$8,000 (incl ded)	
Co-Insurance	20%		30%		30%		10%	
Office Visits								
Primary Care	\$25 ded waived		\$40 ded waived		\$40 ded waived		10% after ded	
Specialist	\$40 ded waived		\$70 ded waived		\$70 ded waived		10% after ded	
Inpatient Services								
Inpatient Hospital	20% after ded		30% after ded; pre-auth req		30% after ded		10% after ded; pre-auth req	
Mental Health Inpatient	20% after ded		30% after ded; pre-auth req		30% after ded		10% after ded; pre-auth req	
Outpatient Services								
Outpatient Facility	Hosp-\$250 after ded; FS-\$150 after ded		30% after ded; pre-auth req		30% after ded		10% after ded; pre-auth req	
Lab/X-Ray	Lab-No charge; X-ray-\$80 after ded		Lab-No charge; X-ray-30% after ded		Lab-No charge; X-ray-30% after ded		10% after ded	
Mental Health Outpatient	\$40 ded waived		\$70 ded waived		\$70 ded waived		10% after ded	
Emergency Care								
Emergency Room	\$400 (waived if admitted) ded waived		\$500 (waived if admitted) ded waived		\$500 (waived if admitted) ded waived		10% after ded	
Urgent Care	\$75 ded waived		\$75 ded waived		\$75 ded waived		10% after ded	
Single	1 x \$829.11		1 x \$787.12		1 x \$727.55		1 x \$835.62	
EE with Spouse	0 x \$1,658.22		0 x \$1,574.24		0 x \$1,455.10		0 x \$1,671.24	
EE with Child(ren)	0 x \$1,409.49		0 x \$1,338.10		0 x \$1,236.84		0 x \$1,420.55	
Family	1 x \$2,362.96		1 x \$2,243.29		1 x \$2,073.52		1 x \$2,381.52	
Monthly Cost	2 \$3,192.07		2 \$3,030.41		2 \$2,801.07		2 \$3,217.14	
Annual Cost	\$38,304.84		\$36,364.92		\$33,612.84		\$38,605.68	

	Oxford Freedom F Gold EPO HSA \$1500 Non-Gated OHI CNT		Oxford Freedom F Silver PPO HSA \$2000 30/60 Non-Gated OHI CNT		Oxford Freedom F Silver EPO HSA \$2000 25/50 Non-Gated OHI CNT		Oxford Freedom F Silver EPO HSA \$2000 Non-Gated OHI CNT	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	10/35/75 IntDed		15/35/75 IntDed		15/35/75 IntDed		15/35/75 IntDed	
Cost Share Information								
Individual/Family Deductible	\$1,500/\$3,000		\$2,000/\$4,000	\$4,000/\$8,000	\$2,000/\$4,000		\$2,000/\$4,000	
Individual/Family OOP Limit	\$4,000/\$8,000 (incl ded)		\$5,500/\$11,000 (incl ded)	\$10,000/\$20,000 (incl ded)	\$5,500/\$11,000 (incl ded)		\$6,550/\$13,100 (incl ded)	
Co-Insurance	10%		20%	50%	20%		30%	
Office Visits								
Primary Care	10% after ded		\$30 after ded	50% after ded	\$25 after ded		30% after ded	
Specialist	10% after ded		\$60 after ded	50% after ded	\$50 after ded		30% after ded	
Inpatient Services								
Inpatient Hospital	10% after ded		20% after ded; pre-auth req	50% after ded; pre-auth req	20% after ded		30% after ded	
Mental Health Inpatient	10% after ded		20% after ded; pre-auth req	50% after ded; pre-auth req	20% after ded		30% after ded	
Outpatient Services								
Outpatient Facility	10% after ded		Hosp-\$250 after ded; FS-\$150 after ded; pre-auth req	50% after ded; pre-auth req	Hosp-\$250 after ded; FS-\$150 after ded		30% after ded	
Lab/X-Ray	10% after ded		20% after ded	50% after ded	Lab-20% after ded; X-ray-\$90 after ded		30% after ded	
Mental Health Outpatient	10% after ded		\$60 after ded	50% after ded	\$50 after ded		30% after ded	
Emergency Care								
Emergency Room	10% after ded		20% after ded	Paid as in-network	\$250 (waived if admitted) after ded		30% after ded	
Urgent Care	10% after ded		\$75 after ded	50% after ded	\$75 after ded		30% after ded	
Single	1 x \$777.74		1 x \$741.82		1 x \$695.96		1 x \$657.95	
EE with Spouse	0 x \$1,555.48		0 x \$1,483.64		0 x \$1,391.92		0 x \$1,315.90	
EE with Child(ren)	0 x \$1,322.16		0 x \$1,261.09		0 x \$1,183.13		0 x \$1,118.52	
Family	1 x \$2,216.56		1 x \$2,114.19		1 x \$1,983.49		1 x \$1,875.16	
Monthly Cost	2 \$2,994.30		2 \$2,856.01		2 \$2,679.45		2 \$2,533.11	
Annual Cost	\$35,931.60		\$34,272.12		\$32,153.40		\$30,397.32	

Prepared For: **Oxford 2017 3rd qtr Freedom NY**

New York County, NY 10001

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

Health Plan Comparison Report (4L)

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SIC: 0000

Oxford Freedom		
F Bronze EPO HSA \$5500 Non-Gated OHI		
CNT		
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/40/80 IntDed	
Cost Share Information		
Individual/Family Deductible	\$5,500/\$11,000	
Individual/Family OOP Limit	\$6,550/\$13,100 (incl ded)	
Co-Insurance	30%	
Office Visits		
Primary Care	30% after ded	
Specialist	30% after ded	
Inpatient Services		
Inpatient Hospital	30% after ded	
Mental Health Inpatient	30% after ded	
Outpatient Services		
Outpatient Facility	30% after ded	
Lab/X-Ray	30% after ded	
Mental Health Outpatient	30% after ded	
Emergency Care		
Emergency Room	30% after ded	
Urgent Care	30% after ded	
Single	1 x	\$572.39
EE with Spouse	0 x	\$1,144.78
EE with Child(ren)	0 x	\$973.06
Family	1 x	\$1,631.31
Monthly Cost	2	\$2,203.70
Annual Cost		\$26,444.40

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