Prepared For: **Oxford 2017 4th qtr Freedom Mid**

Delaware County, NY 12167

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

Health Plan Comparison Report (4L)

Effective Date: 10/01/2017 Prepared On: 08/02/2017

Report ID: 33263582 SIC: 0000

	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	$1,358.96	1 x	$1,208.19	1 x	$1,181.77	1 x	$1,129.11
EE with Spouse	0 x	$2,717.92	0 x	$2,416.38	0 x	$2,363.54	0 x	$2,258.22
EE with Child(ren)	0 x	$2,310.23	0 x	$2,053.92	0 x	$2,009.01	0 x	$1,919.49
Family	1 x	$3,873.04	1 x	$3,443.34	1 x	$3,368.04	1 x	$3,217.96
Monthly Cost	2	$5,232.00	2	$4,651.53	2	$4,549.81	2	$4,347.07
Annual Cost		$62,784.00		$55,818.36		$54,597.72		$52,164.84

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	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	$3,000/$6,000	$800/$1,600		$750/$1,500	
Individual/Family OOP Limit	$3,000/$6,000		$4,000/$8,000 (incl ded)	$7,500/$15,000 (incl ded)	$4,000/$8,000 (incl ded)		$4,000/$8,000 (incl ded)	
Co-Insurance	0%		20%	40%	10%		10%	
Office Visits								
Primary Care	$20		$25 ded waived	40% after ded	$15 ded waived		$50 ded waived	
Specialist	$40		$40 ded waived	40% after ded	$30 ded waived		$50 ded waived	
Inpatient Services								
Inpatient Hospital	$500/admit		20% after ded; pre-auth req	40% 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	40% 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	40% 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	40% 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	40% after ded	$30 ded waived		$50 ded waived	
Emergency Care								
Emergency Room	$200 (waived if admitted)		$300 (waived if admitted) ded waived	Paid as in-network	$400 (waived if admitted) ded waived		$300 (waived if admitted) ded waived	
Urgent Care	$50		$75 ded waived	40% after ded	$75 ded waived		$75 ded waived	
Single	1 x $1,107.40		1 x $1,025.54		1 x $969.32		1 x $960.82	
EE with Spouse	0 x $2,214.80		0 x $2,051.08		0 x $1,938.64		0 x $1,921.64	
EE with Child(ren)	0 x $1,882.58		0 x $1,743.42		0 x $1,647.84		0 x $1,633.39	
Family	1 x $3,156.09		1 x $2,922.79		1 x $2,762.56		1 x $2,738.34	
Monthly Cost	2 $4,263.49		2 $3,948.33		2 $3,731.88		2 $3,699.16	
Annual Cost	$51,161.88		$47,379.96		$44,782.56		$44,389.92	

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	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	$4,000/$8,000	$2,500/$5,000		$1,500/$3,000	$3,000/$6,000
Individual/Family OOP Limit	$5,000/$10,000 (incl ded)		$6,850/$13,700 (incl ded)	$10,000/$20,000 (incl ded)	$6,850/$13,700 (incl ded)		$4,000/$8,000 (incl ded)	$7,500/$15,000 (incl ded)
Co-Insurance	20%		30%	50%	30%		10%	40%
Office Visits								
Primary Care	$25 ded waived		$40 ded waived	50% after ded	$40 ded waived		10% after ded	40% after ded
Specialist	$40 ded waived		$70 ded waived	50% after ded	$70 ded waived		10% after ded	40% after ded
Inpatient Services								
Inpatient Hospital	20% after ded		30% after ded; pre-auth req	50% after ded; pre-auth req	30% after ded		10% after ded; pre-auth req	40% after ded; pre-auth req
Mental Health Inpatient	20% after ded		30% after ded; pre-auth req	50% after ded; pre-auth req	30% after ded		10% after ded; pre-auth req	40% after ded; pre-auth req
Outpatient Services								
Outpatient Facility	Hosp-$250 after ded; FS-$150 after ded		30% after ded; pre-auth req	50% after ded; pre-auth req	30% after ded		10% after ded; pre-auth req	40% after ded; pre-auth req
Lab/X-Ray	Lab-No charge; X-ray-$80 after ded		Lab-No charge; X-ray-30% after ded	50% after ded	Lab-No charge; X-ray-30% after ded		10% after ded	40% after ded
Mental Health Outpatient	$40 ded waived		$70 ded waived	50% after ded	$70 ded waived		10% after ded	40% after ded
Emergency Care								
Emergency Room	$400 (waived if admitted) ded waived		$500 (waived if admitted) ded waived	Paid as in-network	$500 (waived if admitted) ded waived		10% after ded	Paid as in-network
Urgent Care	$75 ded waived		$75 ded waived	50% after ded	$75 ded waived		10% after ded	40% after ded
Single	1 x $932.88		1 x $885.64		1 x $818.61		1 x $940.21	
EE with Spouse	0 x $1,865.76		0 x $1,771.28		0 x $1,637.22		0 x $1,880.42	
EE with Child(ren)	0 x $1,585.90		0 x $1,505.59		0 x $1,391.64		0 x $1,598.36	
Family	1 x $2,658.71		1 x $2,524.07		1 x $2,333.04		1 x $2,679.60	
Monthly Cost	2 $3,591.59		2 $3,409.71		2 $3,151.65		2 $3,619.81	
Annual Cost	$43,099.08		$40,916.52		$37,819.80		$43,437.72	

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	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	$875.08	1 x	$834.66	1 x	$783.06	1 x	$740.30
EE with Spouse	0 x	$1,750.16	0 x	$1,669.32	0 x	$1,566.12	0 x	$1,480.60
EE with Child(ren)	0 x	$1,487.64	0 x	$1,418.92	0 x	$1,331.20	0 x	$1,258.51
Family	1 x	$2,493.98	1 x	$2,378.78	1 x	$2,231.72	1 x	$2,109.86
Monthly Cost	2	$3,369.06	2	$3,213.44	2	$3,014.78	2	$2,850.16
Annual Cost		$40,428.72		$38,561.28		$36,177.36		$34,201.92

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	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	$644.03
EE with Spouse	0 x	$1,288.06
EE with Child(ren)	0 x	$1,094.85
Family	1 x	$1,835.49
Monthly Cost	2	$2,479.52
Annual Cost		$29,754.24

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