

	Oxford Metro P MTRO GT 15/30/100 EPO 20 CNT (EPO) (UCR=N/A)		Oxford Metro G MTRO NG 25/40/1250/80 EPO ME 20 CNT (EPOc) (UCR=N/A)		Oxford Metro G MTRO GT 25/40/1250/80 EPO 20 CNT (EPOc) (UCR=N/A)		Oxford Metro S MTRO NG 50/100/100 EPO ZD 20 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	10/65/90/100 ded T2-3		10/65/90/100 ded T2-3		10/65/90/100 ded T2-3		15/65/90/100 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		\$1,250/\$2,500		\$1,250/\$2,500		N/A	
Individual/Family OOP Limit	\$2,500/\$5,000		\$5,000/\$10,000 (incl ded)		\$5,500/\$11,000 (incl ded)		\$8,150/\$16,300	
Co-Insurance	0%		20%		20%		0%	
Office Visits								
Primary Care	\$15		\$25 ded waived		\$25 ded waived		\$50	
Specialist	\$30		\$40 ded waived		\$40 ded waived		\$100	
Inpatient Services								
Inpatient Hospital	\$200/day; \$800 max/admit		20% after ded		20% after ded		\$1,000/admit	
Mental Health Inpatient	\$200/day; \$800 max/admit		20% after ded		20% after ded		\$1,000/admit	
Outpatient Services								
Outpatient Facility	Hosp-\$500; FS-\$100		Hosp-\$500 after ded; FS-\$200 after ded		Hosp-\$500 after ded; FS-\$200 after ded		Hosp-\$700; FS-\$400	
Lab/X-Ray	Lab-\$15; X-ray-\$20		Lab-\$15 ded waived; X-ray-\$50 after ded		Lab-\$15 ded waived; X-ray-\$50 after ded		Lab-\$20; X-ray-\$100	
Mental Health Outpatient	\$30		\$40 ded waived		\$40 ded waived		\$100	
Emergency Care								
Emergency Room	\$200 (waived if admitted)		\$400 (waived if admitted) ded waived		\$500 (waived if admitted) ded waived		\$1,000	
Urgent Care	\$50		\$65 ded waived		\$65 ded waived		\$100	
Single	2 x \$981.69		2 x \$860.28		2 x \$825.15		2 x \$818.09	
EE with Spouse	0 x \$1,963.39		0 x \$1,720.57		0 x \$1,650.30		0 x \$1,636.17	
EE with Child(ren)	0 x \$1,668.88		0 x \$1,462.49		0 x \$1,402.76		0 x \$1,390.75	
Family	0 x \$2,797.83		0 x \$2,451.81		0 x \$2,351.68		0 x \$2,331.55	
Monthly Cost	2 \$1,963.38		2 \$1,720.56		2 \$1,650.30		2 \$1,636.18	
Annual Cost	\$23,560.56		\$20,646.72		\$19,803.60		\$19,634.16	

	Oxford Metro S MTRO NG 30/80/3000/70 EPO ME 20 CNT (EPOc) (UCR=N/A)		Oxford Metro S MTRO GT 30/80/3000/70 EPO 20 CNT (EPOc) (UCR=N/A)		Oxford Metro S MTRO GT 35/50/3500/70 EPO HSA 20 CNT (HSA) (UCR=N/A)		Oxford Metro B MTRO GT 40/75/5750/50 EPO HSA 20 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	10/65/90/100 ded T2-3		10/65/90/100 ded T2-3		10/65/50%to\$800 IntDed		10/65/90 IntDed	
Cost Share Information								
Individual/Family Deductible	\$3,000/\$6,000		\$3,000/\$6,000		\$3,500/\$7,000		\$5,750/\$11,500	
Individual/Family OOP Limit	\$8,150/\$16,300 (incl ded)		\$8,150/\$16,300 (incl ded)		\$6,750/\$13,500 (incl ded)		\$6,700/\$13,400 (incl ded)	
Co-Insurance	30%		30%		30%		50%	
Office Visits								
Primary Care	\$30 ded waived		\$30 ded waived		\$35 after ded		\$40 after ded	
Specialist	\$80 ded waived		\$80 ded waived		\$50 after ded		\$75 after ded	
Inpatient Services								
Inpatient Hospital	30% after ded		30% after ded		30% after ded		50% after ded	
Mental Health Inpatient	30% after ded		30% after ded		30% after ded		50% after ded	
Outpatient Services								
Outpatient Facility	30% after ded		30% after ded		Hosp-\$750 after ded; FS-\$300 after ded		Hosp-\$1,000 after ded; FS-\$500 after ded	
Lab/X-Ray	Lab-\$20 ded waived; X-ray-30% after ded		Lab-\$20 ded waived; X-ray-30% after ded		Lab-\$15 after ded; X-ray-\$50 after ded		Lab-\$15 after ded; X-ray-50% after ded	
Mental Health Outpatient	\$80 ded waived		\$80 ded waived		\$50 after ded		\$75 after ded	
Emergency Care								
Emergency Room	50% after ded		50% after ded		\$500 (waived if admitted) after ded		\$500 (waived if admitted) after ded	
Urgent Care	\$80 ded waived		\$80 ded waived		\$80 after ded		\$80 after ded	
Single	2 x \$710.17		2 x \$686.22		2 x \$629.70		2 x \$579.35	
EE with Spouse	0 x \$1,420.35		0 x \$1,372.44		0 x \$1,259.41		0 x \$1,158.69	
EE with Child(ren)	0 x \$1,207.30		0 x \$1,166.57		0 x \$1,070.49		0 x \$984.89	
Family	0 x \$2,024.00		0 x \$1,955.73		0 x \$1,794.65		0 x \$1,651.14	
Monthly Cost	2 \$1,420.34		2 \$1,372.44		2 \$1,259.40		2 \$1,158.70	
Annual Cost	\$17,044.08		\$16,469.28		\$15,112.80		\$13,904.40	

Prepared For: **Oxford 2020 4th qtr NY City Metro**

New York County, NY 10001

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

Health Plan Comparison Report (4L)

Effective Date: 10/01/2020

Prepared On: 08/03/2020

Report ID: 37810922

SIC: 0000

Oxford Metro B MTRO GT 6750/100 EPO HSA 20 CNT (HSA) (UCR=N/A)		
	In-Network	Out-Network
Prescription Drugs		
Drug Card	0%/0%/0% IntDed	
Cost Share Information		
Individual/Family Deductible	\$6,750/\$13,500	
Individual/Family OOP Limit	\$6,750/\$13,500 (incl ded)	
Co-Insurance	0%	
Office Visits		
Primary Care	0% after ded	
Specialist	0% after ded	
Inpatient Services		
Inpatient Hospital	0% after ded	
Mental Health Inpatient	0% after ded	
Outpatient Services		
Outpatient Facility	0% after ded	
Lab/X-Ray	0% after ded	
Mental Health Outpatient	0% after ded	
Emergency Care		
Emergency Room	0% after ded	
Urgent Care	0% after ded	
Single	2 x	\$574.57
EE with Spouse	0 x	\$1,149.14
EE with Child(ren)	0 x	\$976.77
Family	0 x	\$1,637.53
Monthly Cost	2	\$1,149.14
Annual Cost		\$13,789.68

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