

	Oxford Metro P MTRO GT 15/30/100 EPO 21 CNT (EPO) (UCR=N/A)		Oxford Metro G MTRO NG 25/40/1250/80 EPO ME 21 CNT (EPOc) (UCR=N/A)		Oxford Metro G MTRO GT 25/40/1250/80 EPO 21 CNT (EPOc) (UCR=N/A)		Oxford Metro S MTRO NG 50/100/100 EPO ZD 21 CNT (EPO) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
<b>Prescription Drugs</b>								
Drug Card	10/65/95/150 ded T2-3		10/65/95/150 ded T2-3		10/65/95/150 ded T2-3		15/65/90/150 ded T2-3	
<b>Cost Share Information</b>								
Individual/Family Deductible	N/A		\$1,250/\$2,500		\$1,250/\$2,500		N/A	
Individual/Family OOP Limit	\$3,000/\$6,000		\$5,500/\$11,000 (incl ded)		\$5,500/\$11,000 (incl ded)		\$8,550/\$17,100	
Co-Insurance	0%		20%		20%		0%	
<b>Office Visits</b>								
Primary Care	\$15		\$25 ded waived		\$25 ded waived		\$50	
Specialist	\$30		\$40 ded waived		\$40 ded waived		\$100	
<b>Inpatient Services</b>								
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	
<b>Outpatient Services</b>								
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-\$500	
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-\$40; X-ray-\$150	
Mental Health Outpatient	\$30		\$40 ded waived		\$40 ded waived		\$100	
<b>Emergency Care</b>								
Emergency Room	\$250 (waived if admitted)		\$500 (waived if admitted) ded waived		\$500 (waived if admitted) ded waived		\$1,350 (waived if admitted)	
Urgent Care	\$50		\$65 ded waived		\$65 ded waived		\$100	
Single	2 x \$982.85		2 x \$847.73		2 x \$826.19		2 x \$793.05	
EE with Spouse	0 x \$1,965.70		0 x \$1,695.46		0 x \$1,652.38		0 x \$1,586.09	
EE with Child(ren)	0 x \$1,670.84		0 x \$1,441.14		0 x \$1,404.52		0 x \$1,348.18	
Family	0 x \$2,801.12		0 x \$2,416.02		0 x \$2,354.63		0 x \$2,260.19	
Monthly Cost	2 \$1,965.70		2 \$1,695.46		2 \$1,652.38		2 \$1,586.10	
Annual Cost	\$23,588.40		\$20,345.52		\$19,828.56		\$19,033.20	

	Oxford Metro S MTRO NG 30/80/3500/70 EPO ME 21 CNT (EPOc) (UCR=N/A)		Oxford Metro S MTRO GT 30/80/3500/70 EPO 21 CNT (EPOc) (UCR=N/A)		Oxford Metro S MTRO GT 35/50/3500/70 EPO HSA 21 CNT (HSA) (UCR=N/A)		Oxford Metro B MTRO GT 40/75/6500/50 EPO HSA 21 CNT (HSA) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
<b>Prescription Drugs</b>								
Drug Card	10/65/95/150 ded T2-3		10/65/95/150 ded T2-3		10/65/50%to\$800 IntDed		10/65/95 IntDed	
<b>Cost Share Information</b>								
Individual/Family Deductible	\$3,500/\$7,000		\$3,500/\$7,000		\$3,500/\$7,000		\$6,500/\$13,000	
Individual/Family OOP Limit	\$8,550/\$17,100 (incl ded)		\$8,550/\$17,100 (incl ded)		\$6,750/\$13,500 (incl ded)		\$7,000/\$14,000 (incl ded)	
Co-Insurance	30%		30%		30%		50%	
<b>Office Visits</b>								
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	
<b>Inpatient Services</b>								
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	
<b>Outpatient Services</b>								
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	
<b>Emergency Care</b>								
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 \$695.15		2 x \$677.48		2 x \$639.62		2 x \$580.68	
EE with Spouse	0 x \$1,390.31		0 x \$1,354.97		0 x \$1,279.24		0 x \$1,161.37	
EE with Child(ren)	0 x \$1,181.76		0 x \$1,151.72		0 x \$1,087.35		0 x \$987.17	
Family	0 x \$1,981.19		0 x \$1,930.84		0 x \$1,822.92		0 x \$1,654.95	
Monthly Cost	2 \$1,390.30		2 \$1,354.96		2 \$1,279.24		2 \$1,161.36	
Annual Cost	\$16,683.60		\$16,259.52		\$15,350.88		\$13,936.32	

Prepared For: **Oxford 2021 1st qtr Metro NY City**

New York County, NY 10001

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

**Health Plan Comparison Report (4L)**

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SIC: 0000

<b>Oxford Metro B MTRO GT 7000/100 EPO HSA 21 CNT (HSA) (UCR=N/A)</b>		
	<b>In-Network</b>	<b>Out-Network</b>
<b>Prescription Drugs</b>		
Drug Card	0%/0%/0% IntDed	
<b>Cost Share Information</b>		
Individual/Family Deductible	\$7,000/\$14,000	
Individual/Family OOP Limit	\$7,000/\$14,000 (incl ded)	
Co-Insurance	0%	
<b>Office Visits</b>		
Primary Care	0% after ded	
Specialist	0% after ded	
<b>Inpatient Services</b>		
Inpatient Hospital	0% after ded	
Mental Health Inpatient	0% after ded	
<b>Outpatient Services</b>		
Outpatient Facility	0% after ded	
Lab/X-Ray	0% after ded	
Mental Health Outpatient	0% after ded	
<b>Emergency Care</b>		
Emergency Room	0% after ded	
Urgent Care	0% after ded	
Single	2 x	\$576.15
EE with Spouse	0 x	\$1,152.31
EE with Child(ren)	0 x	\$979.46
Family	0 x	\$1,642.04
Monthly Cost	2	\$1,152.30
Annual Cost		\$13,827.60

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