Prepared For: **Oxford 2022 2nd qtr Metro Nassau Suffolk**

Nassau County, NY 11565

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

Health Plan Comparison Report (4L)

Effective Date: 04/01/2022 Prepared On: 01/18/2022

Report ID: 38570424 SIC: 0000

	Oxford Metro NY P MTRO GT 15/30/100 EPO 22 CNT (EPO) (UCR=N/A)		Oxford Metro NY G MTRO NG 25/40/1250/80 EPO ME 22 CNT (EPOc) (UCR=N/A)		Oxford Metro NY G MTRO GT 25/40/1250/80 EPO 22 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO NG 50/100/100 EPO ZD 22 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	10/65/95/150 ded T2-3		10/65/95/150 ded T2-3		10/65/95/150 ded T2-3		15/65/95/150 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	$3,250/$6,500		$6,000/$12,000 (incl ded)		$6,000/$12,000 (incl ded)		$8,700/$17,400	
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-$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	
Emergency Care								
Emergency Room	$250 (waived if admitted)		$500 (waived if admitted) ded waived		$500 (waived if admitted) ded waived		$1,400 (waived if admitted)	
Urgent Care	$50		$65 ded waived		$65 ded waived		$100	
Single	2 x $1,119.69		2 x $983.60		2 x $949.42		2 x $917.99	
EE with Spouse	0 x $2,239.38		0 x $1,967.20		0 x $1,898.84		0 x $1,835.98	
EE with Child(ren)	0 x $1,903.47		0 x $1,672.12		0 x $1,614.01		0 x $1,560.58	
Family	0 x $3,191.12		0 x $2,803.26		0 x $2,705.85		0 x $2,616.27	
Monthly Cost	2 $2,239.38		2 $1,967.20		2 $1,898.84		2 $1,835.98	
Annual Cost	$26,872.56		$23,606.40		$22,786.08		$22,031.76	

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

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	Oxford Metro NY S MTRO GT 40/70/3000/65 EPO 22 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO NG 30/80/3500/70 EPO ME 22 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO GT 30/80/3500/70 EPO 22 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO GT 35/50/3500/70 EPO HSA 22 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	10/50/90/200 ded T2-3		10/65/95/150 ded T2-3		10/65/95/150 ded T2-3		10/65/50%to$800 IntDed	
Cost Share Information								
Individual/Family Deductible	$3,000/$6,000		$3,500/$7,000		$3,500/$7,000		$3,500/$7,000	
Individual/Family OOP Limit	$8,700/$17,400 (incl ded)		$8,700/$17,400 (incl ded)		$8,700/$17,400 (incl ded)		$7,050/$14,100 (incl ded)	
Co-Insurance	35%		30%		30%		30%	
Office Visits								
Primary Care	$40 ded waived		$30 ded waived		$30 ded waived		$35 after ded	
Specialist	$70 ded waived		$80 ded waived		$80 ded waived		$50 after ded	
Inpatient Services								
Inpatient Hospital	35% after ded		30% after ded		30% after ded		30% after ded	
Mental Health Inpatient	35% after ded		30% after ded		30% after ded		30% after ded	
Outpatient Services								
Outpatient Facility	35% after ded		30% after ded		30% after ded		Hosp-$750 after ded; FS-$300 after ded	
Lab/X-Ray	Lab-$25 ded waived; X-ray-35% after ded		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	
Mental Health Outpatient	$70 ded waived		$80 ded waived		$80 ded waived		$50 after ded	
Emergency Care								
Emergency Room	50% after ded		50% after ded		50% after ded		$500 (waived if admitted) after ded	
Urgent Care	$75 ded waived		$80 ded waived		$80 ded waived		$80 after ded	
Single	2 x $823.05		2 x $817.55		2 x $789.13		2 x $750.19	
EE with Spouse	0 x $1,646.10		0 x $1,635.10		0 x $1,578.26		0 x $1,500.38	
EE with Child(ren)	0 x $1,399.19		0 x $1,389.84		0 x $1,341.52		0 x $1,275.32	
Family	0 x $2,345.69		0 x $2,330.02		0 x $2,249.02		0 x $2,138.04	
Monthly Cost	2 $1,646.10		2 $1,635.10		2 $1,578.26		2 $1,500.38	
Annual Cost	$19,753.20		$19,621.20		$18,939.12		$18,004.56	

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	Oxford Metro NY B MTRO GT 7000/100 EPO HSA 22 CNT (HSA) (UCR=N/A)		Oxford Metro NY B MTRO GT 40/75/6500/50 EPO HSA 22 CNT (HSA) (UCR=N/A)	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs				
Drug Card	0%/0%/0% IntDed		10/65/95 IntDed	
Cost Share Information				
Individual/Family Deductible	$7,000/$14,000		$6,500/$13,000	
Individual/Family OOP Limit	$7,050/$14,100 (incl ded)		$7,050/$14,100 (incl ded)	
Co-Insurance	0%		50%	
Office Visits				
Primary Care	0% after ded		$40 after ded	
Specialist	0% after ded		$75 after ded	
Inpatient Services				
Inpatient Hospital	0% after ded		50% after ded	
Mental Health Inpatient	0% after ded		50% after ded	
Outpatient Services				
Outpatient Facility	0% after ded		Hosp-$1,000 after ded; FS-$500 after ded	
Lab/X-Ray	0% after ded		Lab-$15 after ded; X-ray-50% after ded	
Mental Health Outpatient	0% after ded		$75 after ded	
Emergency Care				
Emergency Room	0% after ded		$500 (waived if admitted) after ded	
Urgent Care	0% after ded		$80 after ded	
Single	2 x $698.83		2 x $695.85	
EE with Spouse	0 x $1,397.66		0 x $1,391.70	
EE with Child(ren)	0 x $1,188.01		0 x $1,182.95	
Family	0 x $1,991.67		0 x $1,983.17	
Monthly Cost	2 $1,397.66		2 $1,391.70	
Annual Cost	$16,771.92		$16,700.40	

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