Prepared For: **Oxford 2023 1st qtr Freedom NY City**

New York County, NY 10001

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

Health Plan Comparison Report (4L)

Effective Date: 01/01/2023 Prepared On: 10/25/2022

Report ID: 38755834 SIC: 0000

	Oxford Freedom NY P FRDM NG 20/40/100 PPO FAIR 23 CNT (PPO) (UCR=80fh%)		Oxford Freedom NY P FRDM NG 5/15/100 PPO 23 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 20/40/100 PPO 23 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 5/15/100 EPO 23 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	5/35/70/100 ded T2-3		5/35/70/100 ded T2-3		5/35/70/100 ded T2-3		5/35/70/100 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A	$10,000/$20,000	N/A	$2,000/$4,000	N/A	$3,000/$6,000	N/A	
Individual/Family OOP Limit	$3,000/$6,000	$25,000/$50,000 (incl ded)	$3,500/$7,000	$5,250/$10,500 (incl ded)	$3,000/$6,000	$7,750/$15,500 (incl ded)	$3,500/$7,000	
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	$400/admit	20% after ded	$200/admit	30% after ded	$400/admit	30% after ded	$200/admit	
Mental Health Inpatient	$400/admit	20% after ded	$200/admit	30% after ded	$400/admit	30% after ded	$200/admit	
Outpatient Services								
Outpatient Facility	Hosp-$300; FS-$100	20% after ded; pre-auth req	Hosp-$100; FS-$50	30% after ded; pre-auth req	Hosp-$300; FS-$100	30% after ded; pre-auth req	Hosp-$100; FS-$50	
Lab/X-Ray	Lab-No charge/$60 (D/ND); X-ray-$90	Lab-Not covered; X-ray-20% after ded	Lab-No charge/$60 (D/ND); X-ray-$90	Lab-Not covered; X-ray-30% after ded	Lab-No charge/$60 (D/ND); X-ray-$90	Lab-Not covered; X-ray-30% after ded	Lab-No charge/$60 (D/ND); X-ray-$90	
Mental Health Outpatient	$20	20% after ded	5	30% after ded	$20	30% after ded	$5	
Emergency Care								
Emergency Room	$250 (waived if admitted)	Paid as in-network	$250 (waived if admitted)	Paid as in-network	$250 (waived if admitted)	Paid as in-network	$250 (waived if admitted)	
Urgent Care	$50	20% after ded	$50	30% after ded	$50	30% after ded	$50	
Single	2 x $1,727.56		2 x $1,469.66		2 x $1,441.40		2 x $1,415.44	
EE with Spouse	0 x $3,455.13		0 x $2,939.32		0 x $2,882.81		0 x $2,830.89	
EE with Child(ren)	0 x $2,936.85		0 x $2,498.43		0 x $2,450.39		0 x $2,406.25	
Family	0 x $4,923.55		0 x $4,188.53		0 x $4,108.01		0 x $4,034.02	
Monthly Cost	2 $3,455.12		2 $2,939.32		2 $2,882.80		2 $2,830.88	
Annual Cost	$41,461.44		$35,271.84		$34,593.60		$33,970.56	

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	Oxford Freedom NY P FRDM NG 20/40/100 EPO 23 CNT (EPO) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/50/100 EPO ZD 23 CNT (EPO) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/40/1500/80 PPO 23 CNT (PPOc) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 50/50/1000/90 EPO 23 CNT (EPOc) (UCR=N/A)	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs								
Drug Card	5/35/70/100 ded T2-3		10/65/95/150 ded T2-3		10/40/80/150 ded T2-3		10/40/80/150 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		N/A		$1,500/$3,000	$4,000/$8,000	$1,000/$2,000	
Individual/Family OOP Limit	$3,000/$6,000		$6,250/$12,500		$7,050/$14,100 (incl ded)	$10,000/$20,000 (incl ded)	$6,450/$12,900 (incl ded)	
Co-Insurance	0%		0%		20%	40%	10%	
Office Visits								
Primary Care	$20		$25		$25 ded waived	40% after ded	$50 ded waived	
Specialist	$40		$50		$40 ded waived	40% after ded	$50 ded waived	
Inpatient Services								
Inpatient Hospital	$400/admit		$500/admit		20% after ded	40% after ded	$250/day after ded; $2,500 max/admit	
Mental Health Inpatient	$400/admit		$500/admit		20% after ded	40% after ded	$250/day after ded; $2,500 max/admit	
Outpatient Services								
Outpatient Facility	Hosp-$300; FS-$100		Hosp-$500; FS-$150		Hosp-$250 after ded; FS-$150 after ded	40% after ded; pre-auth req	Hosp-$250 after ded; FS-$150 after ded	
Lab/X-Ray	Lab-No charge/$60 (D/ND); X-ray-$90		Lab-No charge/$60 (D/ND); X-ray-$50		Lab-No charge/50% after ded (D/ND); X-ray-$25 after ded	Lab-Not covered; X-ray-40% after ded	Lab-No charge/50% after ded (D/ND); X-ray-$80 after ded	
Mental Health Outpatient	$20		$25		$25 ded waived	40% after ded	$50 ded waived	
Emergency Care								
Emergency Room	$250 (waived if admitted)		$750 (waived if admitted)		$500 (waived if admitted) ded waived	Paid as in-network	$500 (waived if admitted) ded waived	
Urgent Care	$50		$50		$75 ded waived	40% after ded	$75 ded waived	
Single	2 x $1,390.60		2 x $1,257.54		2 x $1,219.73		2 x $1,184.34	
EE with Spouse	0 x $2,781.20		0 x $2,515.08		0 x $2,439.45		0 x $2,368.68	
EE with Child(ren)	0 x $2,364.02		0 x $2,137.82		0 x $2,073.54		0 x $2,013.38	
Family	0 x $3,963.21		0 x $3,583.99		0 x $3,476.22		0 x $3,375.36	
Monthly Cost	2 $2,781.20		2 $2,515.08		2 $2,439.46		2 $2,368.68	
Annual Cost	$33,374.40		$30,180.96		$29,273.52		$28,424.16	

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	Oxford Freedom NY G FRDM NG 15/35/1750/90 EPO 23 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/40/1750/80 EPO 23 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 1500/90 PPO HSA 23 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 1750/100 EPO HSA 23 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	10/40/80/150 ded T2-3		10/40/80/150 ded T2-3		10/40/80 IntDed		10/40/80 IntDed	
Cost Share Information								
Individual/Family Deductible	$1,750/$3,500		$1,750/$3,500		$1,500/$3,000	$4,000/$8,000	$1,750/$3,500	
Individual/Family OOP Limit	$7,750/$15,500 (incl ded)		$6,250/$12,500 (incl ded)		$5,750/$11,500 (incl ded)	$10,000/$20,000 (incl ded)	$7,050/$14,100 (incl ded)	
Co-Insurance	10%		20%		10%	40%	0%	
Office Visits								
Primary Care	$15 ded waived		$25 ded waived		10% after ded	40% after ded	0% after ded	
Specialist	$35 ded waived		$40 ded waived		10% after ded	40% after ded	0% after ded	
Inpatient Services								
Inpatient Hospital	10% after ded		20% after ded		10% after ded	40% after ded	0% after ded	
Mental Health Inpatient	10% after ded		20% after ded		10% after ded	40% after ded	0% after ded	
Outpatient Services								
Outpatient Facility	Hosp-$300 after ded; FS-$150 after ded		Hosp-$250 after ded; FS-$150 after ded		10% after ded	40% after ded	0% after ded	
Lab/X-Ray	Lab-No charge/50% after ded (D/ND); X-ray-$80 after ded		Lab-No charge/50% after ded (D/ND); X-ray-$80 after ded		10% after ded	Lab-Not covered; X-ray-40% after ded	0% after ded	
Mental Health Outpatient	$15 ded waived		$25 ded waived		10% after ded	40% after ded	0% after ded	
Emergency Care								
Emergency Room	$500 (waived if admitted) ded waived		$500 (waived if admitted) ded waived		50% after ded	Paid as in-network	50% after ded	
Urgent Care	$75 ded waived		$75 ded waived		10% after ded	40% after ded	0% after ded	
Single	2 x $1,179.51		2 x $1,169.39		2 x $1,169.33		2 x $1,143.94	
EE with Spouse	0 x $2,359.02		0 x $2,338.79		0 x $2,338.66		0 x $2,287.88	
EE with Child(ren)	0 x $2,005.17		0 x $1,987.97		0 x $1,987.86		0 x $1,944.70	
Family	0 x $3,361.61		0 x $3,332.77		0 x $3,332.59		0 x $3,260.23	
Monthly Cost	2 $2,359.02		2 $2,338.78		2 $2,338.66		2 $2,287.88	
Annual Cost	$28,308.24		$28,065.36		$28,063.92		$27,454.56	

 Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible

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	Oxford Freedom NY G FRDM NG 1500/90 EPO HSA 23 CNT (HSA) (UCR=N/A)		Oxford Freedom NY S FRDM NG 50/100/100 EPO ZD 23 CNT (EPO) (UCR=N/A)		Oxford Freedom NY G FRDM NG 30/60/2250/70 EPO 23 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY S FRDM NG 40/80/3250/60 PPO 23 CNT (PPOc) (UCR=140mc%)	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs								
Drug Card	10/40/80 IntDed		10/65/95/200 ded T2-3		10/40/80/150 ded T2-3		10/50/90/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$1,500/$3,000		N/A		$2,250/$4,500		$3,250/$6,500	$6,000/$12,000
Individual/Family OOP Limit	$5,750/$11,500 (incl ded)		$9,100/$18,200		$8,000/$16,000 (incl ded)		$9,100/$18,200 (incl ded)	$15,000/$30,000 (incl ded)
Co-Insurance	10%		0%		30%		40%	50%
Office Visits								
Primary Care	10% after ded		$50		$30 ded waived		$40 ded waived	50% after ded
Specialist	10% after ded		$100		$60 ded waived		$80 ded waived	50% after ded
Inpatient Services								
Inpatient Hospital	10% after ded		$2,800/admit		30% after ded		40% after ded	50% after ded
Mental Health Inpatient	10% after ded		$2,800/admit		30% after ded		40% after ded	50% after ded
Outpatient Services								
Outpatient Facility	10% after ded		Hosp-$700; FS-$500		30% after ded		40% after ded	50% after ded
Lab/X-Ray	10% after ded		Lab-No charge/$60 (D/ND); X-ray-$150		Lab-No charge/50% after ded (D/ND); X-ray-30% after ded		Lab-No charge/50% after ded (D/ND); X-ray-40% after ded	Lab-Not covered; X-ray-50% after ded
Mental Health Outpatient	10% after ded		$50		$30 ded waived		$40 ded waived	50% after ded
Emergency Care								
Emergency Room	50% after ded		$1,400 (waived if admitted)		$500 (waived if admitted) ded waived		50% after ded	Paid as in-network
Urgent Care	10% after ded		$100		$75 ded waived		$75 ded waived	50% after ded
Single	2 x $1,125.58		2 x $1,117.03		2 x $1,116.51		2 x $1,024.88	
EE with Spouse	0 x $2,251.17		0 x $2,234.06		0 x $2,233.02		0 x $2,049.76	
EE with Child(ren)	0 x $1,913.50		0 x $1,898.94		0 x $1,898.07		0 x $1,742.30	
Family	0 x $3,207.91		0 x $3,183.53		0 x $3,182.05		0 x $2,920.91	
Monthly Cost	2 $2,251.16		2 $2,234.06		2 $2,233.02		2 $2,049.76	
Annual Cost	$27,013.92		$26,808.72		$26,796.24		$24,597.12	

 Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible

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	Oxford Freedom NY S FRDM NG 30/60/2250/70 PPO HSA 23 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY S FRDM NG 40/80/3250/60 EPO 23 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY S FRDM NG 30/60/3000/80 EPO HSA 23 CNT (HSA) (UCR=N/A)		Oxford Freedom NY S FRDM NG 2500/60 EPO HSA 23 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	10/40/80 IntDed		10/50/90/200 ded T2-3		10/40/80 IntDed		10/40/80 IntDed	
Cost Share Information								
Individual/Family Deductible	$2,250/$4,500	$6,000/$12,000	$3,250/$6,500		$3,000/$6,000		$2,500/$5,000	
Individual/Family OOP Limit	$7,350/$14,700 (incl ded)	$15,000/$30,000 (incl ded)	$9,100/$18,200 (incl ded)		$7,150/$14,300 (incl ded)		$7,350/$14,700 (incl ded)	
Co-Insurance	30%	50%	40%		20%		40%	
Office Visits								
Primary Care	$30 after ded	50% after ded	$40 ded waived		$30 after ded		40% after ded	
Specialist	$60 after ded	50% after ded	$80 ded waived		$60 after ded		40% after ded	
Inpatient Services								
Inpatient Hospital	30% after ded	50% after ded	40% after ded		20% after ded		40% after ded	
Mental Health Inpatient	30% after ded	50% after ded	40% after ded		20% after ded		40% after ded	
Outpatient Services								
Outpatient Facility	Hosp-$250 after ded; FS-$150 after ded	50% after ded; pre-auth req	40% after ded		Hosp-$250 after ded; FS-$150 after ded		40% after ded	
Lab/X-Ray	30% after ded	Lab-Not covered; X-ray-50% after ded	Lab-No charge/50% after ded (D/ND); X-ray-40% after ded		Lab-20% after ded; X-ray-$90 after ded		40% after ded	
Mental Health Outpatient	$30 after ded	50% after ded	$40 ded waived		$30 after ded		40% after ded	
Emergency Care								
Emergency Room	50% after ded	Paid as in-network	50% after ded		$500 (waived if admitted) after ded		50% after ded	
Urgent Care	$75 after ded	50% after ded	$75 ded waived		$75 after ded		40% after ded	
Single	2 x $1,024.11		2 x $986.04		2 x $975.21		2 x $956.77	
EE with Spouse	0 x $2,048.22		0 x $1,972.07		0 x $1,950.42		0 x $1,913.54	
EE with Child(ren)	0 x $1,740.98		0 x $1,676.26		0 x $1,657.86		0 x $1,626.51	
Family	0 x $2,918.72		0 x $2,810.20		0 x $2,779.35		0 x $2,726.80	
Monthly Cost	2 $2,048.22		2 $1,972.08		2 $1,950.42		2 $1,913.54	
Annual Cost	$24,578.64		$23,664.96		$23,405.04		$22,962.48	

 Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible

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	Oxford Freedom NY B FRDM NG 5000/50 EPO HSA 23 CNT (HSA) (UCR=N/A)	
	In-Network	**Out-Network**
Prescription Drugs		
Drug Card	10/40/80 IntDed	
Cost Share Information		
Individual/Family Deductible	$5,000/$10,000	
Individual/Family OOP Limit	$7,050/$14,100 (incl ded)	
Co-Insurance	50%	
Office Visits		
Primary Care	50% after ded	
Specialist	50% after ded	
Inpatient Services		
Inpatient Hospital	50% after ded	
Mental Health Inpatient	50% after ded	
Outpatient Services		
Outpatient Facility	50% after ded	
Lab/X-Ray	50% after ded	
Mental Health Outpatient	50% after ded	
Emergency Care		
Emergency Room	50% after ded	
Urgent Care	50% after ded	

Single	2 x	$903.13
EE with Spouse	0 x	$1,806.25
EE with Child(ren)	0 x	$1,535.31
Family	0 x	$2,573.91
Monthly Cost	2	$1,806.26
Annual Cost		$21,675.12

 Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible