Prepared For: **Oxford 2023 3rd qtr Metro New York City**

New York County, NY 10001

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

Health Plan Comparison Report (4L)

Effective Date: 07/01/2023 Prepared On: 04/04/2023

Report ID: 38882721 SIC: 0000

	Oxford Metro NY P MTRO GT 15/25/100 EPO 23 CNT (EPO) (UCR=N/A)		Oxford Metro NY G MTRO NG 25/40/1250/80 EPO ME 23 CNT (EPOc) (UCR=N/A)		Oxford Metro NY G MTRO GT 25/40/1250/80 EPO 23 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO NG 50/100/100 EPO ZD 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	10/65/95/150 ded T2-3		10/65/95/150 ded T2-3		10/65/95/150 ded T2-3		15/65/95/200 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		$6,250/$12,500 (incl ded)		$6,250/$12,500 (incl ded)		$9,100/$18,200	
Co-Insurance	0%		20%		20%		0%	
Office Visits								
Primary Care	$15		$25 ded waived		$25 ded waived		$50	
Specialist	$25		$40 ded waived		$40 ded waived		$100	
Inpatient Services								
Inpatient Hospital	$200/day; $800 max/admit		20% after ded		20% after ded		$2,800/admit	
Mental Health Inpatient	$200/day; $800 max/admit		20% after ded		20% after ded		$2,800/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-No charge/$60 (D/ND); X-ray-$20		Lab-No charge/50% after ded (D/ND); X-ray-$50 after ded		Lab-No charge/50% after ded (D/ND); X-ray-$50 after ded		Lab-No charge/$60 (D/ND); X-ray-$150	
Mental Health Outpatient	$15		$25 ded waived		$25 ded waived		$50	
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 $1,208.26		2 x $1,062.19		2 x $1,025.31		2 x $1,008.62	
EE with Spouse	0 x $2,416.52		0 x $2,124.39		0 x $2,050.62		0 x $2,017.24	
EE with Child(ren)	0 x $2,054.04		0 x $1,805.73		0 x $1,743.02		0 x $1,714.66	
Family	0 x $3,443.54		0 x $3,027.25		0 x $2,922.13		0 x $2,874.57	
Monthly Cost	2 $2,416.52		2 $2,124.38		2 $2,050.62		2 $2,017.24	
Annual Cost	$28,998.24		$25,492.56		$24,607.44		$24,206.88	

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

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	Oxford Metro NY S MTRO GT 40/80/3250/60 EPO 23 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO NG 30/80/3750/60 EPO ME 23 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO GT 30/80/3750/60 EPO 23 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO GT 35/50/4000/70 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	10/50/90/200 ded T2-3		10/65/95/200 ded T2-3		10/65/95/200 ded T2-3		10/65/50%to$800 IntDed	
Cost Share Information								
Individual/Family Deductible	3,250/$6,500		$3,750/$7,500		$3,750/$7,500		$4,000/$8,000	
Individual/Family OOP Limit	$9,100/$18,200 (incl ded)		$9,100/$18,200 (incl ded)		$9,100/$18,200 (incl ded)		$7,200/$14,400 (incl ded)	
Co-Insurance	40%		40%		40%		30%	
Office Visits								
Primary Care	$40 ded waived		$30 ded waived		$30 ded waived		$35 after ded	
Specialist	$80 ded waived		$80 ded waived		$80 ded waived		$50 after ded	
Inpatient Services								
Inpatient Hospital	40% after ded		40% after ded		40% after ded		30% after ded	
Mental Health Inpatient	40% after ded		40% after ded		40% after ded		30% after ded	
Outpatient Services								
Outpatient Facility	40% after ded		40% after ded		40% after ded		Hosp-$750 after ded; FS-$300 after ded	
Lab/X-Ray	Lab-No charge/50% after ded (D/ND); X-ray-40% after ded		Lab-No charge/50% after ded (D/ND); X-ray-40% after ded		Lab-No charge/50% after ded (D/ND); X-ray-40% after ded		Lab-$15 after ded; X-ray-$50 after ded	
Mental Health Outpatient	$40 ded waived		$30 ded waived		$30 ded waived		$35 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 $889.91		2 x $887.61		2 x $856.79		2 x $815.63	
EE with Spouse	0 x $1,779.81		0 x $1,775.22		0 x $1,713.59		0 x $1,631.27	
EE with Child(ren)	0 x $1,512.84		0 x $1,508.93		0 x $1,456.55		0 x $1,386.58	
Family	0 x $2,536.23		0 x $2,529.69		0 x $2,441.87		0 x $2,324.56	
Monthly Cost	2 $1,779.82		2 $1,775.22		2 $1,713.58		2 $1,631.26	
Annual Cost	$21,357.84		$21,302.64		$20,562.96		$19,575.12	

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	Oxford Metro NY B MTRO GT 7000/100 EPO HSA 23 CNT (HSA) (UCR=N/A)		Oxford Metro NY B MTRO GT 40/75/6500/50 EPO HSA 23 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	$7,000/$14,000 (incl ded)		$7,350/$14,700 (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		$40 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 $783.00		2 x $772.03	
EE with Spouse	0 x $1,565.99		0 x $1,544.07	
EE with Child(ren)	0 x $1,331.09		0 x $1,312.45	
Family	0 x $2,231.54		0 x $2,200.30	
Monthly Cost	2 $1,566.00		2 $1,544.06	
Annual Cost	$18,792.00		$18,528.72	