Prepared For: **Oxford 2024 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: 01/01/2024 Prepared On: 10/17/2023

Report ID: 38973733 SIC: 0000

	Oxford Freedom NY P FRDM NG 20/40/100 PPO FAIR 24 CNT (PPO) (UCR=80fh%)		Oxford Freedom NY P FRDM NG 5/15/100 PPO 24 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 20/40/100 PPO 24 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 5/15/100 EPO 24 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	$3,250/$6,500	$25,000/$50,000 (incl ded)	$3,750/$7,500	$5,500/$11,000 (incl ded)	$3,250/$6,500	$8,000/$16,000 (incl ded)	$3,750/$7,500	
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 $1,811.61		2 x $1,545.33		2 x $1,512.84		2 x $1,490.01	
EE with Spouse	0 x $3,623.22		0 x $3,090.66		0 x $3,025.68		0 x $2,980.02	
EE with Child(ren)	0 x $3,079.74		0 x $2,627.06		0 x $2,571.83		0 x $2,533.02	
Family	0 x $5,163.09		0 x $4,404.19		0 x $4,311.59		0 x $4,246.53	
Monthly Cost	2 $3,623.22		2 $3,090.66		2 $3,025.68		2 $2,980.02	
Annual Cost	$43,478.64		$37,087.92		$36,308.16		$35,760.24	

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

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	Oxford Freedom NY P FRDM NG 20/40/100 EPO 24 CNT (EPO) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/50/100 EPO ZD 24 CNT (EPO) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/40/1500/80 PPO 24 CNT (PPOc) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 50/50/1000/90 EPO 24 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	$3,250/$6,500		$7,000/$14,000		$7,250/$14,500 (incl ded)	$10,500/$21,000 (incl ded)	$6,700/$13,400 (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 $1,460.86		2 x $1,329.03		2 x $1,288.02		2 x $1,250.74	
EE with Spouse	0 x $2,921.72		0 x $2,658.06		0 x $2,576.04		0 x $2,501.48	
EE with Child(ren)	0 x $2,483.46		0 x $2,259.35		0 x $2,189.63		0 x $2,126.26	
Family	0 x $4,163.45		0 x $3,787.74		0 x $3,670.86		0 x $3,564.61	
Monthly Cost	2 $2,921.72		2 $2,658.06		2 $2,576.04		2 $2,501.48	
Annual Cost	$35,060.64		$31,896.72		$30,912.48		$30,017.76	

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

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	Oxford Freedom NY G FRDM NG 15/35/1750/90 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/40/1750/80 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 1600/90 PPO HSA 24 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 30/60/2250/70 EPO 24 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	10/40/80/150 ded T2-3		10/40/80/150 ded T2-3		10/40/80 IntDed		10/40/80/150 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$1,750/$3,500		$1,750/$3,500		$1,600/$3,200 (cal yr)	$4,000/$8,000 (cal yr)	$2,250/$4,500	
Individual/Family OOP Limit	$8,000/$16,000 (incl ded)		$6,500/$13,000 (incl ded)		$5,750/$11,500 (incl ded)	$10,500/$21,000 (incl ded)	$8,250/$16,500 (incl ded)	
Co-Insurance	10%		20%		10%	40%	30%	
Office Visits								
Primary Care	$15 ded waived		$25 ded waived		10% after ded	40% after ded	$30 ded waived	
Specialist	$35 ded waived		$40 ded waived		10% after ded	40% after ded	$60 ded waived	
Inpatient Services								
Inpatient Hospital	10% after ded		20% after ded		10% after ded	40% after ded	30% after ded	
Mental Health Inpatient	10% after ded		20% after ded		10% after ded	40% after ded	30% 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	30% 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	Lab-No charge/50% after ded (D/ND); X-ray-30% after ded	
Mental Health Outpatient	$15 ded waived		$25 ded waived		10% after ded	40% after ded	$30 ded waived	
Emergency Care								
Emergency Room	$500 (waived if admitted) ded waived		$500 (waived if admitted) ded waived		50% after ded	Paid as in-network	$500 (waived if admitted) ded waived	
Urgent Care	$75 ded waived		$75 ded waived		10% after ded	40% after ded	$75 ded waived	
Single	2 x $1,246.58		2 x $1,237.15		2 x $1,193.88		2 x $1,184.36	
EE with Spouse	0 x $2,493.16		0 x $2,474.30		0 x $2,387.76		0 x $2,368.72	
EE with Child(ren)	0 x $2,119.19		0 x $2,103.16		0 x $2,029.60		0 x $2,013.41	
Family	0 x $3,552.75		0 x $3,525.88		0 x $3,402.56		0 x $3,375.43	
Monthly Cost	2 $2,493.16		2 $2,474.30		2 $2,387.76		2 $2,368.72	
Annual Cost	$29,917.92		$29,691.60		$28,653.12		$28,424.64	

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

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	Oxford Freedom NY S FRDM NG 50/100/100 EPO ZD 24 CNT (EPO) (UCR=N/A)		Oxford Freedom NY G FRDM NG 2000/100 EPO HSA PR 24 CNT (HSA) (UCR=N/A)		Oxford Freedom NY G FRDM NG 1600/90 EPO HSA 24 CNT (HSA) (UCR=N/A)		Oxford Freedom NY S FRDM NG 40/80/3250/60 PPO 24 CNT (PPOc) (UCR=140mc%)	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs								
Drug Card	15/65/95/200 ded T2-3		10/40/80 IntDed		10/40/80 IntDed		10/50/90/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		$2,000/$4,000		$1,600/$3,200		$3,250/$6,500	$6,000/$12,000
Individual/Family OOP Limit	$9,450/$18,900		$7,050/$14,100 (incl ded)		$5,750/$11,500 (incl ded)		$9,450/$18,900 (incl ded)	$15,500/$31,000 (incl ded)
Co-Insurance	0%		0%		10%		40%	50%
Office Visits								
Primary Care	$50		0% after ded		10% after ded		$40 ded waived	50% after ded
Specialist	$100		0% after ded		10% after ded		$80 ded waived	50% after ded
Inpatient Services								
Inpatient Hospital	$2,800/admit		0% after ded		10% after ded		40% after ded	50% after ded
Mental Health Inpatient	$2,800/admit		0% after ded		10% after ded		40% after ded	50% after ded
Outpatient Services								
Outpatient Facility	Hosp-$500; FS-$250		0% after ded		10% after ded		40% after ded	50% after ded
Lab/X-Ray	Lab-No charge/$60 (D/ND); X-ray-$200		0% after ded		10% 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	$50		0% after ded		10% after ded		$40 ded waived	50% after ded
Emergency Care								
Emergency Room	$1,500 (waived if admitted)		50% after ded		50% after ded		50% after ded	Paid as in-network
Urgent Care	$100		0% after ded		10% after ded		$75 ded waived	50% after ded
Single	2 x $1,173.12		2 x $1,151.29		2 x $1,149.54		2 x $1,078.70	
EE with Spouse	0 x $2,346.24		0 x $2,302.58		0 x $2,299.08		0 x $2,157.40	
EE with Child(ren)	0 x $1,994.30		0 x $1,957.19		0 x $1,954.22		0 x $1,833.79	
Family	0 x $3,343.39		0 x $3,281.18		0 x $3,276.19		0 x $3,074.30	
Monthly Cost	2 $2,346.24		2 $2,302.58		2 $2,299.08		2 $2,157.40	
Annual Cost	$28,154.88		$27,630.96		$27,588.96		$25,888.80	

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	Oxford Freedom NY S FRDM NG 30/60/2250/70 PPO HSA 24 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY S FRDM NG 40/80/3250/60 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY S FRDM NG 30/60/3000/80 EPO HSA 24 CNT (HSA) (UCR=N/A)		Oxford Freedom NY S FRDM NG 2500/60 EPO HSA 24 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	$8,000/$16,000 (incl ded)	$15,500/$31,000 (incl ded)	$9,450/$18,900 (incl ded)		$7,150/$14,300 (incl ded)		$8,000/$16,000 (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 $1,047.37		2 x $1,038.78		2 x $1,009.27		2 x $977.34	
EE with Spouse	0 x $2,094.74		0 x $2,077.56		0 x $2,018.54		0 x $1,954.68	
EE with Child(ren)	0 x $1,780.53		0 x $1,765.93		0 x $1,715.76		0 x $1,661.48	
Family	0 x $2,985.00		0 x $2,960.52		0 x $2,876.42		0 x $2,785.42	
Monthly Cost	2 $2,094.74		2 $2,077.56		2 $2,018.54		2 $1,954.68	
Annual Cost	$25,136.88		$24,930.72		$24,222.48		$23,456.16	

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	Oxford Freedom NY B FRDM NG 5000/50 EPO HSA 24 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	$8,000/$16,000 (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	$910.63
EE with Spouse	0 x	$1,821.26
EE with Child(ren)	0 x	$1,548.07
Family	0 x	$2,595.30
Monthly Cost	2	$1,821.26
Annual Cost		$21,855.12

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