Prepared For: **Oxford 2024 1st qtr Liberty Mid Hudson**

Orange County, NY 10910

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: 38973774 SIC: 0000

	Oxford Liberty NY P LBTY NG 5/35/500/100 EPO PD 24 CNT (EPOc) (UCR=N/A)		**Oxford Liberty NY P LBTY GT 10/25/250/90 EPO LA 24 CNT (EPOc) (UCR=N/A)**		**Oxford Liberty NY G LBTY NG 25/50/100 EPO ZD 24 CNT (EPO) (UCR=N/A)**		**Oxford Liberty NY G LBTY NG 20/40/1500/80 EPO PD 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	10/50/90/200 ded T2-3		10/50/90/200 ded T2-3		10/50/90/200 ded T2-3		10/50/90/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$500/$1,000		$250/$500		N/A		$1,500/$3,000	
Individual/Family OOP Limit	$2,450/$4,900 (incl ded)		$2,750/$5,500 (incl ded)		$7,000/$14,000		$8,750/$17,500 (incl ded)	
Co-Insurance	0%		10%		0%		20%	
Office Visits								
Primary Care	D-$5 ded waived; ND-$25 ded waived		$10 ded waived		$25		D-$20 ded waived; ND-$40 ded waived	
Specialist	D-$35 ded waived; ND-$70 ded waived		$25 ded waived		$50		D-$40 ded waived; ND-$80 ded waived	
Inpatient Services								
Inpatient Hospital	0% after ded		10% after ded		$500/admit		20% after ded	
Mental Health Inpatient	0% after ded		10% after ded		$500/admit		20% after ded	
Outpatient Services								
Outpatient Facility	0% after ded		10% after ded		Hosp-$500; FS-$150		20% after ded	
Lab/X-Ray	Lab-50% after ded; X-ray-0% after ded		Lab-No charge/50% after ded (D/ND); X-ray-10% after ded		Lab-No charge/$60 (D/ND); X-ray-$50		Lab-50% after ded; X-ray-20% after ded	
Mental Health Outpatient	$5 ded waived		$10 ded waived		$25		$20 ded waived	
Emergency Care								
Emergency Room	$250 ded waived		50% after ded		$750 (waived if admitted)		$500 ded waived	
Urgent Care	$75 ded waived		$30 ded waived		$50		$75 ded waived	
Single	2 x $1,266.93		2 x $1,202.30		2 x $1,184.12		2 x $1,076.62	
EE with Spouse	0 x $2,533.86		0 x $2,404.60		0 x $2,368.24		0 x $2,153.24	
EE with Child(ren)	0 x $2,153.78		0 x $2,043.91		0 x $2,013.00		0 x $1,830.25	
Family	0 x $3,610.75		0 x $3,426.56		0 x $3,374.74		0 x $3,068.37	
Monthly Cost	2 $2,533.86		2 $2,404.60		2 $2,368.24		2 $2,153.24	
Annual Cost	$30,406.32		$28,855.20		$28,418.88		$25,838.88	

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 Liberty NY G LBTY GT 30/60/1250/100 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY G LBTY NG 30/60/1800/70 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY S LBTY NG 50/100/100 EPO ZD 24 CNT (EPO) (UCR=N/A)		Oxford Liberty NY G LBTY NG 1600/90 EPO HSA PR 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	10/50/90/200 ded T2-3		10/50/90/200 ded T2-3		15/65/95/200 ded T2-3		10/50/90 IntDed	
Cost Share Information								
Individual/Family Deductible	$1,250/$2,500		$1,800/$3,600		N/A		$1,600/$3,200	
Individual/Family OOP Limit	$7,000/$14,000 (incl ded)		$8,000/$16,000 (incl ded)		$9,450/$18,900		$5,750/$11,500 (incl ded)	
Co-Insurance	0%		30%		0%		10%	
Office Visits								
Primary Care	$30 ded waived		$30 ded waived		$50		10% after ded	
Specialist	$60 ded waived		$60 ded waived		$100		10% after ded	
Inpatient Services								
Inpatient Hospital	$500/day after ded; $2,000 max/admit		30% after ded		$2,800/admit		10% after ded	
Mental Health Inpatient	$500/day after ded; $2,000 max/admit		30% after ded		$2,800/admit		10% after ded	
Outpatient Services								
Outpatient Facility	Hosp-$250 after ded; FS-$150 after ded		30% after ded		Hosp-$500; FS-$250		10% after ded	
Lab/X-Ray	Lab-No charge/50% after ded (D/ND); X-ray-$35 after ded		Lab-No charge/50% after ded (D/ND); X-ray-30% after ded		Lab-No charge/$60 (D/ND); X-ray-$200		10% after ded	
Mental Health Outpatient	$30 ded waived		$30 ded waived		$50		10% after ded	
Emergency Care								
Emergency Room	$500 (waived if admitted) ded waived		$500 (waived if admitted) ded waived		$1,500 (waived if admitted)		50% after ded	
Urgent Care	$75 ded waived		$75 ded waived		$100		10% after ded	
Single	2 x $1,073.02		2 x $1,058.46		2 x $1,048.63		2 x $1,026.53	
EE with Spouse	0 x $2,146.04		0 x $2,116.92		0 x $2,097.26		0 x $2,053.06	
EE with Child(ren)	0 x $1,824.13		0 x $1,799.38		0 x $1,782.67		0 x $1,745.10	
Family	0 x $3,058.11		0 x $3,016.61		0 x $2,988.60		0 x $2,925.61	
Monthly Cost	2 $2,146.04		2 $2,116.92		2 $2,097.26		2 $2,053.06	
Annual Cost	$25,752.48		$25,403.04		$25,167.12		$24,636.72	

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

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	Oxford Liberty NY S LBTY NG 40/80/3250/60 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY S LBTY NG 25/45/5000/50 EPO PD 24 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY S LBTY NG 30/75/4000/50 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY S LBTY NG 30/60/3000/80 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	10/50/90/200 ded T2-3		10/50/90/200 ded T2-3		10/50/90/200 ded T2-3		10/50/90 IntDed	
Cost Share Information								
Individual/Family Deductible	$3,250/$6,500		$5,000/$10,000		$4,000/$8,000		$3,000/$6,000	
Individual/Family OOP Limit	$9,450/$18,900 (incl ded)		$9,450/$18,900 (incl ded)		$9,450/$18,900 (incl ded)		$7,150/$14,300 (incl ded)	
Co-Insurance	40%		50%		50%		20%	
Office Visits								
Primary Care	$40 ded waived		D-$25 ded waived; ND-$45 ded waived		$30 ded waived		$30 after ded	
Specialist	$80 ded waived		D-$45 ded waived; ND-$75 ded waived		$75 ded waived		$60 after ded	
Inpatient Services								
Inpatient Hospital	40% after ded		50% after ded		50% after ded		20% after ded	
Mental Health Inpatient	40% after ded		50% after ded		50% after ded		20% after ded	
Outpatient Services								
Outpatient Facility	40% after ded		50% after ded		50% after ded		Hosp-$250 after ded; FS-$150 after ded	
Lab/X-Ray	Lab-No charge/50% after ded (D/ND); X-ray-40% after ded		Lab-50% after ded; X-ray-50% after ded		Lab-No charge/50% after ded (D/ND); X-ray-50% after ded		Lab-20% after ded; X-ray-$90 after ded	
Mental Health Outpatient	$40 ded waived		$25 ded waived		$30 ded waived		$30 after ded	
Emergency Care								
Emergency Room	50% after ded		50% after ded		$600 (waived if admitted) after ded		$500 (waived if admitted) after ded	
Urgent Care	$75 ded waived		$75 ded waived		$80 ded waived		$75 after ded	
Single	2 x $928.07		2 x $923.34		2 x $915.04		2 x $900.99	
EE with Spouse	0 x $1,856.14		0 x $1,846.68		0 x $1,830.08		0 x $1,801.98	
EE with Child(ren)	0 x $1,577.72		0 x $1,569.68		0 x $1,555.57		0 x $1,531.68	
Family	0 x $2,645.00		0 x $2,631.52		0 x $2,607.86		0 x $2,567.82	
Monthly Cost	2 $1,856.14		2 $1,846.68		2 $1,830.08		2 $1,801.98	
Annual Cost	$22,273.68		$22,160.16		$21,960.96		$21,623.76	

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	Oxford Liberty NY S LBTY GT 30/60/4500/50 EPO 24 CNT (EPOc) (UCR=N/A)		**Oxford Liberty NY S LBTY NG 4000/80 EPO HSA PR 24 CNT (HSA) (UCR=N/A)**		**Oxford Liberty NY B LBTY NG 30/60/6750/80 PPO HSA 24 CNT (HSA) (UCR=140mc%)**		**Oxford Liberty NY B LBTY NG 7250/100 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	10/50/90/200 ded T2-3		10/50/90 IntDed		10/50/90 IntDed		0%/0%/0% IntDed	
Cost Share Information								
Individual/Family Deductible	$4,500/$9,000		$4,000/$8,000		$6,750/$13,500	$12,500/$25,000	$7,250/$14,500	
Individual/Family OOP Limit	$9,450/$18,900 (incl ded)		$8,000/$16,000 (incl ded)		$8,000/$16,000 (incl ded)	$31,250/$62,500 (incl ded)	$7,250/$14,500 (incl ded)	
Co-Insurance	50%		20%		20%	20%	0%	
Office Visits								
Primary Care	$30 ded waived		20% after ded		$30 after ded	20% after ded	0% after ded	
Specialist	$60 ded waived		20% after ded		$60 after ded	20% after ded	0% after ded	
Inpatient Services								
Inpatient Hospital	50% after ded		20% after ded		20% after ded	20% after ded	0% after ded	
Mental Health Inpatient	50% after ded		20% after ded		20% after ded	20% after ded	0% after ded	
Outpatient Services								
Outpatient Facility	50% after ded		20% after ded		20% after ded	20% after ded	0% after ded	
Lab/X-Ray	Lab-No charge/50% after ded (D/ND); X-ray-50% after ded		20% after ded		20% after ded	Lab-Not covered; X-ray-20% after ded	0% after ded	
Mental Health Outpatient	$30 ded waived		20% after ded		$30 after ded	20% after ded	0% after ded	
Emergency Care								
Emergency Room	50% after ded		50% after ded		50% after ded	Paid as in-network	0% after ded	
Urgent Care	$80 ded waived		20% after ded		20% after ded	20% after ded	0% after ded	
Single	2 x $895.66		2 x $852.93		2 x $833.52		2 x $822.17	
EE with Spouse	0 x $1,791.32		0 x $1,705.86		0 x $1,667.04		0 x $1,644.34	
EE with Child(ren)	0 x $1,522.62		0 x $1,449.98		0 x $1,416.98		0 x $1,397.69	
Family	0 x $2,552.63		0 x $2,430.85		0 x $2,375.53		0 x $2,343.18	
Monthly Cost	2 $1,791.32		2 $1,705.86		2 $1,667.04		2 $1,644.34	
Annual Cost	$21,495.84		$20,470.32		$20,004.48		$19,732.08	

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

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	Oxford Liberty NY B LBTY NG 25/75/5750/70 EPO HSA 24 CNT (HSA) (UCR=N/A)	
	In-Network	**Out-Network**
Prescription Drugs		
Drug Card	30%/30%/30% IntDed	
Cost Share Information		
Individual/Family Deductible	$5,750/$11,500	
Individual/Family OOP Limit	$8,000/$16,000 (incl ded)	
Co-Insurance	30%	
Office Visits		
Primary Care	$25 after ded	
Specialist	$75 after ded	
Inpatient Services		
Inpatient Hospital	30% after ded	
Mental Health Inpatient	30% after ded	
Outpatient Services		
Outpatient Facility	30% after ded	
Lab/X-Ray	30% after ded	
Mental Health Outpatient	$25 after ded	
Emergency Care		
Emergency Room	50% after ded	
Urgent Care	30% after ded	
Single	2 x $808.96	
EE with Spouse	0 x $1,617.92	
EE with Child(ren)	0 x $1,375.23	
Family	0 x $2,305.54	
Monthly Cost	2 $1,617.92	
Annual Cost	$19,415.04	

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