

	Oxford Metro NY P MTRO GT 15/25/100 EPO 24 CNT (EPO) (UCR=N/A)		Oxford Metro NY G MTRO NG 25/40/1250/80 EPO ME 24 CNT (EPOc) (UCR=N/A)		Oxford Metro NY G MTRO GT 25/40/1250/80 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO NG 50/100/100 EPO ZD 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	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	\$3,500/\$7,000		\$6,500/\$13,000 (incl ded)		\$6,500/\$13,000 (incl ded)		\$9,450/\$18,900	
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-\$500; FS-\$250	
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-\$200	
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		\$1,500 (waived if admitted)	
Urgent Care	\$50		\$65 ded waived		\$65 ded waived		\$100	
Single	2 x \$1,142.90		2 x \$1,004.95		2 x \$970.06		2 x \$952.71	
EE with Spouse	0 x \$2,285.80		0 x \$2,009.90		0 x \$1,940.12		0 x \$1,905.42	
EE with Child(ren)	0 x \$1,942.93		0 x \$1,708.42		0 x \$1,649.10		0 x \$1,619.61	
Family	0 x \$3,257.27		0 x \$2,864.11		0 x \$2,764.67		0 x \$2,715.22	
Monthly Cost	2 \$2,285.80		2 \$2,009.90		2 \$1,940.12		2 \$1,905.42	
Annual Cost	\$27,429.60		\$24,118.80		\$23,281.44		\$22,865.04	

	Oxford Metro NY S MTRO NG 30/80/3750/60 EPO ME 24 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO GT 30/80/3750/60 EPO 24 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO GT 35/50/4000/70 EPO HSA 24 CNT (HSA) (UCR=N/A)		Oxford Metro NY B MTRO GT 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	10/65/95/200 ded T2-3		10/65/95/200 ded T2-3		10/65/50%to\$800 IntDed		0%/0%/0% IntDed	
Cost Share Information								
Individual/Family Deductible	\$3,750/\$7,500		\$3,750/\$7,500		\$4,000/\$8,000		\$7,250/\$14,500	
Individual/Family OOP Limit	\$9,450/\$18,900 (incl ded)		\$9,450/\$18,900 (incl ded)		\$7,200/\$14,400 (incl ded)		\$7,250/\$14,500 (incl ded)	
Co-Insurance	40%		40%		30%		0%	
Office Visits								
Primary Care	\$30 ded waived		\$30 ded waived		\$35 after ded		0% after ded	
Specialist	\$80 ded waived		\$80 ded waived		\$50 after ded		0% after ded	
Inpatient Services								
Inpatient Hospital	40% after ded		40% after ded		30% after ded		0% after ded	
Mental Health Inpatient	40% after ded		40% after ded		30% after ded		0% after ded	
Outpatient Services								
Outpatient Facility	40% after ded		40% after ded		Hosp-\$750 after ded; FS-\$300 after ded		0% 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-\$15 after ded; X-ray-\$50 after ded		0% after ded	
Mental Health Outpatient	\$30 ded waived		\$30 ded waived		\$35 after ded		0% after ded	
Emergency Care								
Emergency Room	50% after ded		50% after ded		\$500 (waived if admitted) after ded		0% after ded	
Urgent Care	\$80 ded waived		\$80 ded waived		\$80 after ded		0% after ded	
Single	2 x \$840.38		2 x \$811.20		2 x \$762.47		2 x \$721.78	
EE with Spouse	0 x \$1,680.76		0 x \$1,622.40		0 x \$1,524.94		0 x \$1,443.56	
EE with Child(ren)	0 x \$1,428.65		0 x \$1,379.04		0 x \$1,296.20		0 x \$1,227.03	
Family	0 x \$2,395.08		0 x \$2,311.92		0 x \$2,173.04		0 x \$2,057.07	
Monthly Cost	2 \$1,680.76		2 \$1,622.40		2 \$1,524.94		2 \$1,443.56	
Annual Cost	\$20,169.12		\$19,468.80		\$18,299.28		\$17,322.72	

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

Orange County, NY 10910

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

Health Plan Comparison Report (4L)

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SIC: 0000

Oxford Metro NY B MTRO GT 40/75/6500/50 EPO HSA 24 CNT (HSA) (UCR=N/A)		
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/65/95 IntDed	
Cost Share Information		
Individual/Family Deductible	\$6,500/\$13,000	
Individual/Family OOP Limit	\$8,000/\$16,000 (incl ded)	
Co-Insurance	50%	
Office Visits		
Primary Care	\$40 after ded	
Specialist	\$75 after ded	
Inpatient Services		
Inpatient Hospital	50% after ded	
Mental Health Inpatient	50% after ded	
Outpatient Services		
Outpatient Facility	Hosp-\$1,000 after ded; FS-\$500 after ded	
Lab/X-Ray	Lab-\$15 after ded; X-ray-50% after ded	
Mental Health Outpatient	\$40 after ded	
Emergency Care		
Emergency Room	\$500 (waived if admitted) after ded	
Urgent Care	\$80 after ded	
Single	2 x	\$704.77
EE with Spouse	0 x	\$1,409.54
EE with Child(ren)	0 x	\$1,198.11
Family	0 x	\$2,008.59
Monthly Cost	2	\$1,409.54
Annual Cost		\$16,914.48

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