Prepared For: **Oxford 2025 3rd qtr Freedom New York City**

New York County, NY 10001

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

Health Plan Comparison Report (4L)

Effective Date: 07/01/2025 Prepared On: 04/29/2025

Report ID: 39233911 SIC: 0000

	Oxford Freedom NY P FRDM NG 20/40/100 PPO FAIR 25 CNT (PPO) (UCR=80fh%)		Oxford Freedom NY P FRDM NG 5/15/100 PPO 25 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 20/40/100 PPO 25 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 5/15/100 EPO 25 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	$300	20% after ded; pre-auth req	$100	30% after ded; pre-auth req	$300	30% after ded; pre-auth req	$100	
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	$40	20% after ded	$15	30% after ded	$40	30% after ded	$15	
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 $2,001.01		2 x $1,676.80		2 x $1,643.44		2 x $1,618.56	
EE with Spouse	0 x $4,002.02		0 x $3,353.60		0 x $3,286.88		0 x $3,237.12	
EE with Child(ren)	0 x $3,401.72		0 x $2,850.55		0 x $2,793.85		0 x $2,751.55	
Family	0 x $5,702.88		0 x $4,778.87		0 x $4,683.81		0 x $4,612.89	
Monthly Cost	2 $4,002.02		2 $3,353.60		2 $3,286.88		2 $3,237.12	
Annual Cost	$48,024.24		$40,243.20		$39,442.56		$38,845.44	

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	Oxford Freedom NY P FRDM NG 15/25/100 EPO 25 CNT (EPO) (UCR=N/A)		Oxford Freedom NY P FRDM NG 20/40/100 EPO 25 CNT (EPO) (UCR=N/A)		Oxford Freedom NY P FRDM NG 10/25/250/90 EPO 25 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/50/100 EPO ZD 25 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		5/35/70/100 ded T2-3		5/35/70/100 ded T2-3		10/65/95/150 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		N/A		$250/$500		N/A	
Individual/Family OOP Limit	$3,500/$7,000		$3,250/$6,500		$2,750/$5,500 (incl ded)		$7,000/$14,000	
Co-Insurance	0%		0%		10%		0%	
Office Visits								
Primary Care	$15		$20		$10 ded waived		$25	
Specialist	$25		$40		$25 ded waived		$50	
Inpatient Services								
Inpatient Hospital	$200/day; $800 max/admit		$400/admit		10% after ded		$500/admit	
Mental Health Inpatient	$200/day; $800 max/admit $200/day; $800 max/admit		$400/admit		10% after ded		$500/admit	
Outpatient Services								
Outpatient Facility	$100		$300		10% after ded		$250	
Lab/X-Ray	Lab-No charge/$60 (D/ND); X-ray-$200		Lab-No charge/$60 (D/ND); X-ray-$90		Lab-No charge/50% after ded (D/ND); X-ray-10% after ded		Lab-No charge/$60 (D/ND); X-ray-$50	
Mental Health Outpatient	$25		$40		$25 ded waived		$50	
Emergency Care								
Emergency Room	$250 (waived if admitted)		$250 (waived if admitted)		50% after ded		$750 (waived if admitted)	
Urgent Care	$50		$50		$50 ded waived		$75	
Single	2 x $1,592.78		2 x $1,588.60		2 x $1,537.53		2 x $1,442.55	
EE with Spouse	0 x $3,185.55		0 x $3,177.21		0 x $3,075.06		0 x $2,885.09	
EE with Child(ren)	0 x $2,707.72		0 x $2,700.63		0 x $2,613.80		0 x $2,452.33	
Family	0 x $4,539.41		0 x $4,527.52		0 x $4,381.97		0 x $4,111.26	
Monthly Cost	2 $3,185.56		2 $3,177.20		2 $3,075.06		2 $2,885.10	
Annual Cost	$38,226.72		$38,126.40		$36,900.72		$34,621.20	

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	Oxford Freedom NY G FRDM NG 25/40/1500/80 PPO 25 CNT (PPOc) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 50/50/1000/90 EPO 25 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 15/35/1750/90 EPO 25 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/40/1750/80 EPO 25 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		10/40/80/150 ded T2-3		10/40/80/150 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$1,500/$3,000	$4,000/$8,000	$1,000/$2,000		$1,750/$3,500		$1,750/$3,500	
Individual/Family OOP Limit	$7,250/$14,500 (incl ded)	$10,500/$21,000 (incl ded)	$6,700/$13,400 (incl ded)		$8,000/$16,000 (incl ded)		$6,500/$13,000 (incl ded)	
Co-Insurance	20%	40%	10%		10%		20%	
Office Visits								
Primary Care	$25 ded waived	40% after ded	$50 ded waived		$15 ded waived		$25 ded waived	
Specialist	$40 ded waived	40% after ded	$50 ded waived		$35 ded waived		$40 ded waived	
Inpatient Services								
Inpatient Hospital	20% after ded	40% after ded	$250/day after ded		10% after ded		20% after ded	
Mental Health Inpatient	20% after ded	40% after ded	$250/day after ded		10% after ded		20% after ded	
Outpatient Services								
Outpatient Facility	$150 after ded	40% after ded; pre-auth req	$150 after ded		$150 after ded		$150 after ded	
Lab/X-Ray	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		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	
Mental Health Outpatient	$40 ded waived	40% after ded	$50 ded waived		$35 ded waived		$40 ded waived	
Emergency Care								
Emergency Room	$500 (waived if admitted) ded waived	Paid as in-network	$500 (waived if admitted) ded waived		$500 (waived if admitted) ded waived		$500 (waived if admitted) ded waived	
Urgent Care	$75 ded waived	40% after ded	$75 ded waived		$75 ded waived		$75 ded waived	
Single	2 x $1,402.17		2 x $1,363.92		2 x $1,353.05		2 x $1,346.36	
EE with Spouse	0 x $2,804.34		0 x $2,727.83		0 x $2,706.10		0 x $2,692.73	
EE with Child(ren)	0 x $2,383.69		0 x $2,318.66		0 x $2,300.18		0 x $2,288.82	
Family	0 x $3,996.18		0 x $3,887.17		0 x $3,856.20		0 x $3,837.14	
Monthly Cost	2 $2,804.34		2 $2,727.84		2 $2,706.10		2 $2,692.72	
Annual Cost	$33,652.08		$32,734.08		$32,473.20		$32,312.64	

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

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	Oxford Freedom NY G FRDM NG 1650/90 PPO HSA 25 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 30/60/2250/70 EPO 25 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 2000/100 EPO HSA PR 25 CNT (HSA) (UCR=N/A)		Oxford Freedom NY G FRDM NG 1650/90 EPO HSA 25 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		10/40/80/150 ded T2-3		10/40/80 IntDed		10/40/80 IntDed	
Cost Share Information								
Individual/Family Deductible	$1,650/$3,300	$4,000/$8,000	$2,250/$4,500		$2,000/$4,000		$1,650/$3,300	
Individual/Family OOP Limit	$5,750/$11,500 (incl ded)	$10,500/$21,000 (incl ded)	$7,250/$14,500 (incl ded)		$7,050/$14,100 (incl ded)		$5,750/$11,500 (incl ded)	
Co-Insurance	10%	40%	30%		0%		10%	
Office Visits								
Primary Care	10% after ded	40% after ded	$30 ded waived		0% after ded		10% after ded	
Specialist	10% after ded	40% after ded	$60 ded waived		0% after ded		10% after ded	
Inpatient Services								
Inpatient Hospital	10% after ded	40% after ded	30% after ded		0% after ded		10% after ded	
Mental Health Inpatient	10% after ded	40% after ded	30% after ded		0% after ded		10% after ded	
Outpatient Services								
Outpatient Facility	10% after ded	40% after ded	30% after ded		0% after ded		10% after ded	
Lab/X-Ray	10% after ded	Lab-Not covered; X-ray-40% after ded	Lab-No charge/50% after ded (D/ND); X-ray-30% after ded		0% after ded		10% after ded	
Mental Health Outpatient	10% after ded	40% after ded	$60 ded waived		0% after ded		10% after ded	
Emergency Care								
Emergency Room	50% after ded	Paid as in-network	$500 (waived if admitted) ded waived		50% after ded		50% after ded	
Urgent Care	10% after ded	40% after ded	$75 ded waived		0% after ded		10% after ded	
Single	2 x $1,333.46		2 x $1,299.29		2 x $1,290.71		2 x $1,285.99	
EE with Spouse	0 x $2,666.93		0 x $2,598.59		0 x $2,581.42		0 x $2,571.99	
EE with Child(ren)	0 x $2,266.89		0 x $2,208.80		0 x $2,194.20		0 x $2,186.19	
Family	0 x $3,800.37		0 x $3,702.99		0 x $3,678.52		0 x $3,665.08	
Monthly Cost	2 $2,666.92		2 $2,598.58		2 $2,581.42		2 $2,571.98	
Annual Cost	$32,003.04		$31,182.96		$30,977.04		$30,863.76	

 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 25 CNT (EPO) (UCR=N/A)		Oxford Freedom NY S FRDM NG 40/80/3250/60 PPO 25 CNT (PPOc) (UCR=140mc%)		Oxford Freedom NY S FRDM NG 30/60/2250/70 PPO HSA 25 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY S FRDM NG 40/80/3250/60 EPO 25 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	15/65/95/200 ded T2-3		10/50/90/200 ded T2-3		10/40/80 IntDed		10/50/90/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		$3,250/$6,500	$6,000/$12,000	$2,250/$4,500	$6,000/$12,000	$3,250/$6,500	
Individual/Family OOP Limit	$9,200/$18,400		$9,200/$18,400 (incl ded)	$15,500/$31,000 (incl ded)	$8,000/$16,000 (incl ded)	$15,500/$31,000 (incl ded)	$9,200/$18,400 (incl ded)	
Co-Insurance	0%		40%	50%	30%	50%	40%	
Office Visits								
Primary Care	$50		$40 ded waived	50% after ded	$30 after ded	50% after ded	$40 ded waived	
Specialist	$100		$80 ded waived	50% after ded	$60 after ded	50% after ded	$80 ded waived	
Inpatient Services								
Inpatient Hospital	$1,500/admit		40% after ded	50% after ded	30% after ded	50% after ded	40% after ded	
Mental Health Inpatient	$1,500/admit		40% after ded	50% after ded	30% after ded	50% after ded	40% after ded	
Outpatient Services								
Outpatient Facility	$250		40% after ded	50% after ded	$150 after ded	50% after ded; pre-auth req	40% after ded	
Lab/X-Ray	Lab-No charge/$60 (D/ND); X-ray-$200		Lab-No charge/50% after ded (D/ND); X-ray-40% after ded	Lab-Not covered; X-ray-50% after ded	30% after ded	Lab-Not covered; X-ray-50% after ded	Lab-No charge/50% after ded (D/ND); X-ray-40% after ded	
Mental Health Outpatient	$100		$80 ded waived	50% after ded	$60 after ded	50% after ded	$80 ded waived	
Emergency Care								
Emergency Room	$1,500 (waived if admitted)		50% after ded	Paid as in-network	50% after ded	Paid as in-network	50% after ded	
Urgent Care	$100		$100 ded waived	50% after ded	$100 after ded	50% after ded	$100 ded waived	
Single	2 x $1,284.48		2 x $1,185.61		2 x $1,178.08		2 x $1,143.26	
EE with Spouse	0 x $2,568.95		0 x $2,371.22		0 x $2,356.16		0 x $2,286.52	
EE with Child(ren)	0 x $2,183.61		0 x $2,015.54		0 x $2,002.73		0 x $1,943.54	
Family	0 x $3,660.76		0 x $3,379.00		0 x $3,357.53		0 x $3,258.29	
Monthly Cost	2 $2,568.96		2 $2,371.22		2 $2,356.16		2 $2,286.52	
Annual Cost	$30,827.52		$28,454.64		$28,273.92		$27,438.24	

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

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	Oxford Freedom NY S FRDM NG 30/60/3000/80 EPO HSA 25 CNT (HSA) (UCR=N/A)		Oxford Freedom NY S FRDM NG 2500/60 EPO HSA 25 CNT (HSA) (UCR=N/A)		Oxford Freedom NY B FRDM NG 30/60/6750/80 PPO HSA 25 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY B FRDM NG 5000/50 EPO HSA 25 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		10/40/80 IntDed		10/50/90 IntDed		10/40/80 IntDed	
Cost Share Information								
Individual/Family Deductible	$3,000/$6,000		$2,500/$5,000		$6,750/$13,500	$12,500/$25,000	$5,000/$10,000	
Individual/Family OOP Limit	$7,150/$14,300 (incl ded)		$8,000/$16,000 (incl ded)		$8,000/$16,000 (incl ded)	$31,250/$62,500 (incl ded)	$8,000/$16,000 (incl ded)	
Co-Insurance	20%		40%		20%	20%	50%	
Office Visits								
Primary Care	$30 after ded		40% after ded		$30 after ded	20% after ded	50% after ded	
Specialist	$60 after ded		40% after ded		$60 after ded	20% after ded	50% after ded	
Inpatient Services								
Inpatient Hospital	20% after ded		40% after ded		20% after ded	20% after ded	50% after ded	
Mental Health Inpatient	20% after ded		40% after ded		20% after ded	20% after ded	50% after ded	
Outpatient Services								
Outpatient Facility	$250 after ded		40% after ded		20% after ded	20% after ded; pre-auth req	50% after ded	
Lab/X-Ray	Lab-20% after ded; X-ray-$90 after ded		40% after ded		20% after ded	Lab-Not covered; X-ray-20% after ded	50% after ded	
Mental Health Outpatient	$60 after ded		40% after ded		$60 after ded	20% after ded	50% after ded	
Emergency Care								
Emergency Room	$500 (waived if admitted) after ded		50% after ded		50% after ded	Paid as in-network	50% after ded	
Urgent Care	$100 after ded		40% after ded		20% after ded	20% after ded	50% after ded	
Single	2 x $1,139.34		2 x $1,103.85		2 x $1,055.63		2 x $1,032.75	
EE with Spouse	0 x $2,278.69		0 x $2,207.69		0 x $2,111.25		0 x $2,065.50	
EE with Child(ren)	0 x $1,936.89		0 x $1,876.53		0 x $1,794.56		0 x $1,755.68	
Family	0 x $3,247.13		0 x $3,145.96		0 x $3,008.53		0 x $2,943.34	
Monthly Cost	2 $2,278.68		2 $2,207.70		2 $2,111.26		2 $2,065.50	
Annual Cost	$27,344.16		$26,492.40		$25,335.12		$24,786.00	

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