### Prepared For: Oxford 2017 3rd qtr Liberty Mid

Delaware County, NY 12167

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

## Health Plan Comparison Report (4L)

Effective Date: 07/01/2017

Report ID: 32844790

Prepared On: 04/20/2017 SIC: 0000

	Oxford Liberty L Gold EPO 30/60 Gated OHI CNT		Oxford Liberty L Silver EPO 40/70 Non-Gated OHI CNT		Oxford Liberty L Silver EPO 25/50 Gated OHI CNT		Oxford Liberty L Silver EPO 30/75 Non-Gated OHI CNT	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs		ournetwork		ournetwork		ournetwork		ournetwork
Drug Card	15/35/75/100 ded T2-3		15/45/75/100 ded T2-3		15/65/85/100 ded T2-3		15/65/50%to\$800/100 ded T2-3	
Cost Share Information								
ndividual/Family Deductible ndividual/Family OOP Limit	\$1,000/\$2,000 \$4,000/\$8,000 (incl ded)		\$2,500/\$5,000 \$6,850/\$13,700 (incl ded)		\$3,000/\$6,000 \$6,600/\$13,200 (incl ded)		\$3,000/\$6,000 \$6,850/\$13,700 (incl ded)	
Co-Insurance	0%		30%		50%		40%	
Office Visits								
Primary Care Specialist	\$30 ded waived \$60 ded waived		\$40 ded waived \$70 ded waived		\$25 ded waived \$50 ded waived		\$30 ded waived \$75 ded waived	
Inpatient Services								
npatient Hospital	\$500/day after ded; \$2,000 max/admit		30% after ded		50% after ded		40% after ded	
Mental Health Inpatient	\$500/day after ded; \$2,000 max/admit		30% after ded		50% after ded		40% after ded	
Outpatient Services								
Outpatient Facility	Hosp-\$250 after ded; FS- \$150 after ded		30% after ded		50% after ded		40% after ded	
_ab/X-Ray	Lab-No charge; X-ray-\$35 after ded		Lab-No charge; X-ray-30% after ded		Lab-No charge; X-ray-50% after ded		Lab-No charge; X-ray-40% after ded	
Mental Health Outpatient	\$60 ded waived		\$70 ded waived		\$50 ded waived		\$75 ded waived	
Emergency Care								
Emergency Room	\$200 (waived if admitted) ded waived		\$500 (waived if admitted) ded waived		\$500 (waived if admitted) ded waived		\$500 (waived if admitted) after ded	
Jrgent Care	\$75 ded waived		\$75 ded waived		\$80 ded waived		\$80 ded waived	
Single	1 x \$885.83		1 x \$777.07		1 x \$747.50		1 x \$730.20	
EE with Spouse	0 x \$1,771.66		0 x \$1,554.14		0 x \$1,495.00		0 x \$1,460.40	
EE with Child(ren) Family	0 x \$1,505.91 1 x \$2,524.62		0 x \$1,321.02 1 x \$2,214.65		0 x \$1,270.75 1 x \$2,130.38		0 x \$1,241.34 1 x \$2,081.07	
Monthly Cost	2 \$3,410.45		2 \$2,991.72		2 \$2,877.88		2 \$2,811.27	
Annual Cost	\$40,925.40		\$35,900.64		\$34,534.56		\$33,735.24	

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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**Out-Network** 

Prepared By: Clifford Grekin Inc. - (631)963-6020 **Oxford Liberty Oxford Liberty Oxford Libertv Oxford Libertv** L Silver EPO HSA \$2000 25/50 Non-Gated Bronze PPO HSA \$6000 30/60 Non-Gated L Bronze EPO HSA \$6550 100% Non-Gated L Silver EPO Prim Adv \$2000 Non-Gated **OHI CNT OHI CNT OHI CNT OHI CNT** In-Network **Out-Network** In-Network **Out-Network** In-Network Out-Network In-Network **Prescription Drugs** 15/35/75 IntDed T2-3 15/35/75 IntDed 15/35/75 IntDed Drug Card 0%/0%/0% IntDed Cost Share Information Individual/Family Deductible \$2,000/\$4,000 \$2,000/\$4,000 \$6,000/\$12,000 \$10,000/\$20,000 \$6,550/\$13,100 Individual/Family OOP Limit \$5,500/\$11,000 (incl ded) \$5,500/\$11,000 (incl ded) \$6,550/\$13,100 (incl ded) \$25,000/\$50,000 (incl \$6,550/\$13,100 (incl ded) ded) 30% 20% 20% 20% 0% Co-Insurance Office Visits Primary Care \$25 ded waived \$25 after ded \$30 after ded 20% after ded 0% after ded \$50 after ded 0% after ded \$50 after ded \$60 after ded 20% after ded Specialist Inpatient Services Inpatient Hospital \$250/day after ded; 20% after ded 20% after ded; pre-auth 20% after ded; pre-auth 0% after ded \$1,250 max/admit req req Mental Health Inpatient \$250/day after ded; 20% after ded 20% after ded; pre-auth 20% after ded; pre-auth 0% after ded \$1.250 max/admit rea req **Outpatient Services** Outpatient Facility Hosp-\$250 after ded: FS-Hosp-\$250 after ded: FS-20% after ded; pre-auth 20% after ded: pre-auth 0% after ded \$150 after ded \$150 after ded req req Lab/X-Ray Lab-\$50 after ded; X-ray-Lab-20% after ded; X-ray-20% after ded 20% after ded 0% after ded \$90 after ded \$90 after ded \$50 ded waived \$50 after ded \$60 after ded 20% after ded 0% after ded Mental Health Outpatient Emergency Care Emergency Room 30% after ded \$250 (waived if admitted) 20% after ded Paid as in-network 0% after ded after ded Urgent Care \$75 after ded \$75 after ded 20% after ded 20% after ded 0% after ded Single \$741.08 \$743.33 \$653.13 \$604.13 1 x 1 x 1 x 1 x EE with Spouse 0 x \$1,482.16 0 x \$1,486.66 0 x \$1,306.26 0 x \$1,208.26 EE with Child(ren) 0 x \$1,259.84 0 x \$1,263.66 0 x \$1,110.32 0 x \$1,027.02 Family 1 x \$2,112.08 1 x \$2,118.49 1 x \$1,861.42 1 x \$1,721.77 2 2 2 2 Monthly Cost \$2.853.16 \$2.861.82 \$2.514.55 \$2.325.90 Annual Cost \$34.237.92 \$34.341.84 \$30.174.60 \$27.910.80

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	Oxford Liberty L Bronze EPO HSA \$5500 Non-Gated OHI CNT		
	In-Net	work	Out-Network
Prescription Drugs			
Drug Card	10/40/80 IntD	Ded	
Cost Share Information			
Individual/Family Deductible	\$5,500/\$11,0	00	
Individual/Family OOP Limit	\$6,550/\$13,1	00 (incl ded)	
Co-Insurance	30%		
Office Visits		ľ	
Primary Care	30% after de	d	
Specialist	30% after de	d	
Inpatient Services			
Inpatient Hospital	30% after de	d	
Mental Health Inpatient	30% after de	d	
Outpatient Services		I	
Outpatient Facility	30% after de	d	
Lab/X-Ray	30% after de	d	
Mental Health Outpatient	30% after de	d	
Emergency Care			
Emergency Room	30% after ded		
Urgent Care	30% after de	d	
Single	1 x	\$611.36	
EE with Spouse	0 x	\$1,222.72	
EE with Child(ren)	0 x	\$1,039.31	
Family	1 x	\$1,742.38	
Monthly Cost	2	\$2,353.74	
Annual Cost	2	\$28,244.88	

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