

	Oxford Metro M Platinum EPO 15/30 Gated OHI CNT (EPO) (UCR=N/A)		Oxford Metro M Gold EPO 25/40 Non-Gated OHI CNT (EPOc) (UCR=N/A)		Oxford Metro M Gold EPO 25/40 Gated OHI CNT (EPOc) (UCR=N/A)		Oxford Metro M Silver EPO 30/80 Non-Gated OHI 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	10/65/90/100 ded T2-3		10/65/90/100 ded T2-3		10/65/90/100 ded T2-3		10/65/90/100 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		\$1,250/\$2,500		\$1,250/\$2,500		\$3,000/\$6,000	
Individual/Family OOP Limit	\$2,500/\$5,000		\$5,000/\$10,000 (incl ded)		\$5,500/\$11,000 (incl ded)		\$7,900/\$15,800 (incl ded)	
Co-Insurance	0%		20%		20%		30%	
Office Visits								
Primary Care	\$15		\$25 ded waived		\$25 ded waived		\$30 ded waived	
Specialist	\$30		\$40 ded waived		\$40 ded waived		\$80 ded waived	
Inpatient Services								
Inpatient Hospital	\$200/day; \$800 max/admit		20% after ded		20% after ded		30% after ded	
Mental Health Inpatient	\$200/day; \$800 max/admit		20% after ded		20% after ded		30% after ded	
Outpatient Services								
Outpatient Facility	Hosp-\$500; FS-\$100		Hosp-\$500 after ded; FS-\$200 after ded		Hosp-\$500 after ded; FS-\$200 after ded		30% after ded	
Lab/X-Ray	Lab-\$15; X-ray-\$20		Lab-\$15 ded waived; X-ray-\$50 after ded		Lab-\$15 ded waived; X-ray-\$50 after ded		Lab-\$15 ded waived; X-ray-30% after ded	
Mental Health Outpatient	\$30		\$40 ded waived		\$40 ded waived		\$80 ded waived	
Emergency Care								
Emergency Room	\$200 (waived if admitted)		\$400 (waived if admitted) ded waived		\$500 (waived if admitted) ded waived		30% after ded	
Urgent Care	\$50		\$65 ded waived		\$65 ded waived		\$80 ded waived	
Single	1 x \$879.11		1 x \$768.55		1 x \$737.78		1 x \$648.08	
EE with Spouse	0 x \$1,758.22		0 x \$1,537.09		0 x \$1,475.56		0 x \$1,296.16	
EE with Child(ren)	0 x \$1,494.49		0 x \$1,306.53		0 x \$1,254.23		0 x \$1,101.74	
Family	1 x \$2,505.46		1 x \$2,190.35		1 x \$2,102.66		1 x \$1,847.03	
Monthly Cost	2 \$3,384.57		2 \$2,958.90		2 \$2,840.44		2 \$2,495.11	
Annual Cost	\$40,614.84		\$35,506.80		\$34,085.28		\$29,941.32	

	Oxford Metro M Silver EPO 30/80 Gated OHI CNT (EPOc) (UCR=N/A)		Oxford Metro M Silver EPO HSA \$1500 35/50 Gated OHI CNT (HSA) (UCR=N/A)		Oxford Metro M Silver EPO Prim Adv \$3000 Gated OHI CNT (EPOc) (UCR=N/A)		Oxford Metro M Bronze EPO HSA \$5500 Gated OHI 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	10/65/90/100 ded T2-3		10/65/50%to\$800 IntDed		5/65/90 IntDed T2-3		10/65/90 IntDed	
Cost Share Information								
Individual/Family Deductible	\$3,000/\$6,000		\$1,500/\$3,000		\$3,000/\$6,000		\$5,500/\$11,000	
Individual/Family OOP Limit	\$7,900/\$15,800 (incl ded)		\$6,550/\$13,100 (incl ded)		\$7,900/\$15,800 (incl ded)		\$6,700/\$13,400 (incl ded)	
Co-Insurance	30%		30%		30%		30%	
Office Visits								
Primary Care	\$30 ded waived		\$35 after ded		\$15 ded waived		30% after ded	
Specialist	\$80 ded waived		\$50 after ded		\$70 after ded		30% after ded	
Inpatient Services								
Inpatient Hospital	30% after ded		30% after ded		\$400/day after ded; \$1,600 max/admit		30% after ded	
Mental Health Inpatient	30% after ded		30% after ded		\$400/day after ded; \$1,600 max/admit		30% after ded	
Outpatient Services								
Outpatient Facility	30% after ded		Hosp-\$750 after ded; FS-\$300 after ded		Hosp-\$500 after ded; FS-\$250 after ded		30% after ded	
Lab/X-Ray	Lab-\$15 ded waived; X-ray-30% after ded		Lab-\$15 after ded; X-ray-\$50 after ded		\$15 after ded		Lab-\$15 after ded; X-ray-30% after ded	
Mental Health Outpatient	\$80 ded waived		\$50 after ded		\$70 ded waived		30% after ded	
Emergency Care								
Emergency Room	30% after ded		\$500 (waived if admitted) after ded		50% after ded		30% after ded	
Urgent Care	\$80 ded waived		\$80 after ded		\$70 ded waived		30% after ded	
Single	1 x \$626.27		1 x \$624.83		1 x \$596.76		1 x \$520.42	
EE with Spouse	0 x \$1,252.54		0 x \$1,249.65		0 x \$1,193.52		0 x \$1,040.85	
EE with Child(ren)	0 x \$1,064.66		0 x \$1,062.21		0 x \$1,014.49		0 x \$884.72	
Family	1 x \$1,784.87		1 x \$1,780.75		1 x \$1,700.76		1 x \$1,483.20	
Monthly Cost	2 \$2,411.14		2 \$2,405.58		2 \$2,297.52		2 \$2,003.62	
Annual Cost	\$28,933.68		\$28,866.96		\$27,570.24		\$24,043.44	

Prepared For: **Oxford 2019 4th qtr Metro NY City**

New York County, NY 10001

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

Health Plan Comparison Report (4L)

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	Oxford Metro M Bronze EPO HSA \$5750 40/75 Gated OHI CNT (HSA) (UCR=N/A)		Oxford Metro M Bronze EPO HSA \$6550 100% Gated OHI CNT (HSA) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs				
Drug Card	10/65/90 IntDed		0%/0%/0% IntDed	
Cost Share Information				
Individual/Family Deductible	\$5,750/\$11,500		\$6,550/\$13,100	
Individual/Family OOP Limit	\$6,700/\$13,400 (incl ded)		\$6,700/\$13,400 (incl ded)	
Co-Insurance	50%		0%	
Office Visits				
Primary Care	\$40 after ded		0% after ded	
Specialist	\$75 after ded		0% after ded	
Inpatient Services				
Inpatient Hospital	50% after ded		0% after ded	
Mental Health Inpatient	50% after ded		0% after ded	
Outpatient Services				
Outpatient Facility	Hosp-\$1,000 after ded; FS-\$500 after ded		0% after ded	
Lab/X-Ray	Lab-\$15 after ded; X-ray-50% after ded		0% after ded	
Mental Health Outpatient	\$75 after ded		0% after ded	
Emergency Care				
Emergency Room	\$500 (waived if admitted) after ded		0% after ded	
Urgent Care	\$80 after ded		0% after ded	
Single	1 x \$515.70		1 x \$515.28	
EE with Spouse	0 x \$1,031.39		0 x \$1,030.55	
EE with Child(ren)	0 x \$876.69		0 x \$875.97	
Family	1 x \$1,469.73		1 x \$1,468.54	
Monthly Cost	2 \$1,985.43		2 \$1,983.82	
Annual Cost	\$23,825.16		\$23,805.84	

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