Prepared For: **Oxford 2022 1st qtr Liberty NY City**

New York County, NY 10001

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

Health Plan Comparison Report (4L)

Effective Date: 01/01/2022 Prepared On: 10/26/2021

Report ID: 38462960 SIC: 0000

	Oxford Liberty NY P LBTY NG 5/35/500/100 EPO 22 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY P LBTY GT 15/30/250/90 EPO LA 22 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY G LBTY NG 25/50/100 EPO ZD 22 CNT (EPO) (UCR=N/A)		Oxford Liberty NY G LBTY GT 30/60/1250/100 EPO 22 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		$1,250/$2,500	
Individual/Family OOP Limit	$3,050/$6,100 (incl ded)		$3,250/$6,500 (incl ded)		$6,000/$12,000		$6,400/$12,800 (incl ded)	
Co-Insurance	0%		10%		0%		0%	
Office Visits								
Primary Care	D-$5 ded waived; ND-$25 ded waived		$15 ded waived		$25		$30 ded waived	
Specialist	D-$35 ded waived; ND-$70 ded waived		$30 ded waived		$50		$60 ded waived	
Inpatient Services								
Inpatient Hospital	0% after ded		10% after ded		$500/admit		$500/day after ded; $2,000 max/admit	
Mental Health Inpatient	0% after ded		10% after ded		$500/admit		$500/day after ded; $2,000 max/admit	
Outpatient Services								
Outpatient Facility	0% after ded		10% after ded		Hosp-$500; FS-$150		Hosp-$250 after ded; FS-$150 after ded	
Lab/X-Ray	0% after ded		10% after ded		Lab-$20; X-ray-$50		Lab-No charge; X-ray-$35 after ded	
Mental Health Outpatient	$35 ded waived		$30 ded waived		$50		$60 ded waived	
Emergency Care								
Emergency Room	$250 ded waived		50% after ded		$750 (waived if admitted)		$500 (waived if admitted) ded waived	
Urgent Care	$75 ded waived		$30 ded waived		$50		$75 ded waived	
Single	2 x $1,215.93		2 x $1,142.72		2 x $1,122.90		2 x $1,027.56	
EE with Spouse	0 x $2,431.86		0 x $2,285.44		0 x $2,245.80		0 x $2,055.12	
EE with Child(ren)	0 x $2,067.08		0 x $1,942.62		0 x $1,908.93		0 x $1,746.85	
Family	0 x $3,465.40		0 x $3,256.75		0 x $3,200.27		0 x $2,928.55	
Monthly Cost	2 $2,431.86		2 $2,285.44		2 $2,245.80		2 $2,055.12	
Annual Cost	$29,182.32		$27,425.28		$26,949.60		$24,661.44	

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

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	Oxford Liberty NY G LBTY NG 1500/90 EPO HSAM 22 CNT (HSA) (UCR=N/A)		Oxford Liberty NY G LBTY NG 20/40/2000/80 EPO 22 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY G LBTY NG 30/60/2000/70 EPO 22 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY S LBTY NG 50/100/100 EPO ZD 22 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	10/50/90 IntDed		10/50/90/200 ded T2-3		10/50/90/200 ded T2-3		10/65/95/150 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$1,500/$3,000		$2,000/$4,000		$2,000/$4,000		N/A	
Individual/Family OOP Limit	$5,500/$11,000 (incl ded)		$8,500/$17,000 (incl ded)		$8,400/$16,800 (incl ded)		$8,700/$17,400	
Co-Insurance	10%		20%		30%		0%	
Office Visits								
Primary Care	10% after ded		D-$20 ded waived; ND-$40 ded waived		$30 ded waived		$50	
Specialist	10% after ded		D-$40 ded waived; ND-$80 ded waived		$60 ded waived		$100	
Inpatient Services								
Inpatient Hospital	10% after ded		20% after ded		30% after ded		$1,000/admit	
Mental Health Inpatient	10% after ded		20% after ded		30% after ded		$1,000/admit	
Outpatient Services								
Outpatient Facility	10% after ded		20% after ded		30% after ded		Hosp-$700; FS-$500	
Lab/X-Ray	10% after ded		20% after ded		Lab-No charge; X-ray-30% after ded		Lab-$40; X-ray-$150	
Mental Health Outpatient	10% after ded		$40 ded waived		$60 ded waived		$100	
Emergency Care								
Emergency Room	50% after ded		$500 ded waived		$500 (waived if admitted) ded waived		$1,400 (waived if admitted)	
Urgent Care	10% after ded		$75 ded waived		$75 ded waived		$100	
Single	2 x $1,002.20		2 x $1,000.29		2 x $989.96		2 x $983.16	
EE with Spouse	0 x $2,004.40		0 x $2,000.58		0 x $1,979.92		0 x $1,966.32	
EE with Child(ren)	0 x $1,703.74		0 x $1,700.49		0 x $1,682.93		0 x $1,671.37	
Family	0 x $2,856.27		0 x $2,850.83		0 x $2,821.39		0 x $2,802.01	
Monthly Cost	2 $2,004.40		2 $2,000.58		2 $1,979.92		2 $1,966.32	
Annual Cost	$24,052.80		$24,006.96		$23,759.04		$23,595.84	

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

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	Oxford Liberty NY S LBTY NG 40/70/3000/65 EPO 22 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY S LBTY NG 25/50/2500/80 EPO HSA 22 CNT (HSA) (UCR=N/A)		Oxford Liberty NY S LBTY NG 40/70/4500/60 EPO 22 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY S LBTY NG 30/75/3500/60 EPO 22 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 IntDed		10/50/90/200 ded T2-3		10/50/50%to$800/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$3,000/$6,000		$2,500/$5,000		$4,500/$9,000		$3,500/$7,000	
Individual/Family OOP Limit	$8,700/$17,400 (incl ded)		$6,900/$13,800 (incl ded)		$8,700/$17,400 (incl ded)		$8,700/$17,400 (incl ded)	
Co-Insurance	35%		20%		40%		40%	
Office Visits								
Primary Care	$40 ded waived		$25 after ded		$40 ded waived		$30 ded waived	
Specialist	$70 ded waived		$50 after ded		$70 ded waived		$75 ded waived	
Inpatient Services								
Inpatient Hospital	35% after ded		20% after ded		40% after ded		40% after ded	
Mental Health Inpatient	35% after ded		20% after ded		40% after ded		40% after ded	
Outpatient Services								
Outpatient Facility	35% after ded		Hosp-$250 after ded; FS-$150 after ded		40% after ded		40% after ded	
Lab/X-Ray	Lab-$25 ded waived; X-ray-35% after ded		Lab-20% after ded; X-ray-$90 after ded		Lab-$25 ded waived; X-ray-40% after ded		Lab-$20 ded waived; X-ray-40% after ded	
Mental Health Outpatient	$70 ded waived		$50 after ded		$70 ded waived		$75 ded waived	
Emergency Care								
Emergency Room	50% after ded		$500 (waived if admitted) after ded		50% after ded		$600 (waived if admitted) after ded	
Urgent Care	$75 ded waived		$75 after ded		$75 ded waived		$80 ded waived	
Single	2 x $881.48		2 x $880.71		2 x $864.59		2 x $863.18	
EE with Spouse	0 x $1,762.96		0 x $1,761.42		0 x $1,729.18		0 x $1,726.36	
EE with Child(ren)	0 x $1,498.52		0 x $1,497.21		0 x $1,469.80		0 x $1,467.41	
Family	0 x $2,512.22		0 x $2,510.02		0 x $2,464.08		0 x $2,460.06	
Monthly Cost	2 $1,762.96		2 $1,761.42		2 $1,729.18		2 $1,726.36	
Annual Cost	$21,155.52		$21,137.04		$20,750.16		$20,716.32	

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

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	Oxford Liberty NY S LBTY NG 25/45/5000/50 EPO 22 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY S LBTY GT 25/50/4500/50 EPO 22 CNT (EPOc) (UCR=N/A)		Oxford Liberty NY S LBTY NG 4000/80 EPO HSAM 22 CNT (HSA) (UCR=N/A)		Oxford Liberty NY B LBTY NG 30/60/6750/80 PPO HSA 22 CNT (HSA) (UCR=140mc%)	
	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 IntDed		10/50/90 IntDed	
Cost Share Information								
Individual/Family Deductible	$5,000/$10,000		$4,500/$9,000		$4,000/$8,000		$6,750/$13,500	$10,000/$20,000
Individual/Family OOP Limit	$8,700/$17,400 (incl ded)		$8,700/$17,400 (incl ded)		$7,050/$14,100 (incl ded)		$7,050/$14,100 (incl ded)	$25,000/$50,000 (incl ded)
Co-Insurance	50%		50%		20%		20%	20%
Office Visits								
Primary Care	D-$25 ded waived; ND-$45 ded waived		$25 ded waived		20% after ded		$30 after ded	20% after ded
Specialist	D-$45 ded waived; ND-$75 ded waived		$50 ded waived		20% after ded		$60 after ded	20% after ded
Inpatient Services								
Inpatient Hospital	50% after ded		50% after ded		20% after ded		20% after ded; pre-auth req	20% after ded; pre-auth req
Mental Health Inpatient	50% after ded		50% after ded		20% after ded		20% after ded; pre-auth req	20% after ded; pre-auth req
Outpatient Services								
Outpatient Facility	50% after ded		50% after ded		20% after ded		20% after ded; pre-auth req	20% after ded; pre-auth req
Lab/X-Ray	50% after ded		Lab-$15 ded waived; X-ray-50% after ded		20% after ded		20% after ded	Lab-Not covered; X-ray-20% after ded
Mental Health Outpatient	$45 ded waived		$50 ded waived		20% after ded		$60 after ded	20% after ded
Emergency Care								
Emergency Room	50% after ded		50% after ded		50% after ded		50% after ded	Paid as in-network
Urgent Care	$75 ded waived		$80 ded waived		20% after ded		20% after ded	20% after ded
Single	2 x $854.92		2 x $846.84		2 x $828.09		2 x $809.01	
EE with Spouse	0 x $1,709.84		0 x $1,693.68		0 x $1,656.18		0 x $1,618.02	
EE with Child(ren)	0 x $1,453.36		0 x $1,439.63		0 x $1,407.75		0 x $1,375.32	
Family	0 x $2,436.52		0 x $2,413.49		0 x $2,360.06		0 x $2,305.68	
Monthly Cost	2 $1,709.84		2 $1,693.68		2 $1,656.18		2 $1,618.02	
Annual Cost	$20,518.08		$20,324.16		$19,874.16		$19,416.24	

 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 22 CNT (HSA) (UCR=N/A)		Oxford Liberty NY B LBTY NG 7000/100 EPO HSA 22 CNT (HSA) (UCR=N/A)	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs				
Drug Card	30%/30%/30% IntDed		0%/0%/0% IntDed	
Cost Share Information				
Individual/Family Deductible	$5,750/$11,500		$7,000/$14,000	
Individual/Family OOP Limit	$7,050/$14,100 (incl ded)		$7,050/$14,100 (incl ded)	
Co-Insurance	30%		0%	
Office Visits				
Primary Care	$25 after ded		0% after ded	
Specialist	$75 after ded		0% after ded	
Inpatient Services				
Inpatient Hospital	30% after ded		0% after ded	
Mental Health Inpatient	30% after ded		0% after ded	
Outpatient Services				
Outpatient Facility	30% after ded		0% after ded	
Lab/X-Ray	30% after ded		0% after ded	
Mental Health Outpatient	$75 after ded		0% after ded	
Emergency Care				
Emergency Room	50% after ded		0% after ded	
Urgent Care	30% after ded		0% after ded	
Single	2 x $775.97		2 x $775.38	
EE with Spouse	0 x $1,551.94		0 x $1,550.76	
EE with Child(ren)	0 x $1,319.15		0 x $1,318.15	
Family	0 x $2,211.51		0 x $2,209.83	
Monthly Cost	2 $1,551.94		2 $1,550.76	
Annual Cost	$18,623.28		$18,609.12	

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