

	Oxford Metro NY G MTRO NG 25/40/1250/80 EPO ME 25 CNT (EPOc) (UCR=N/A)		Oxford Metro NY G MTRO GT 25/40/1250/80 EPO 25 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO NG 50/100/100 EPO ZD 25 CNT (EPO) (UCR=N/A)		Oxford Metro NY S MTRO NG 30/80/3750/60 EPO ME 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	10/65/95/150 ded T2-3		10/65/95/150 ded T2-3		15/65/95/200 ded T2-3		10/65/95/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	\$1,250/\$2,500		\$1,250/\$2,500		N/A		\$3,750/\$7,500	
Individual/Family OOP Limit	\$6,500/\$13,000 (incl ded)		\$6,500/\$13,000 (incl ded)		\$9,200/\$18,400		\$9,200/\$18,400 (incl ded)	
Co-Insurance	20%		20%		0%		40%	
Office Visits								
Primary Care	\$25 ded waived		\$25 ded waived		\$50		\$30 ded waived	
Specialist	\$40 ded waived		\$40 ded waived		\$100		\$80 ded waived	
Inpatient Services								
Inpatient Hospital	20% after ded		20% after ded		\$1,500/admit		40% after ded	
Mental Health Inpatient	20% after ded		20% after ded		\$1,500/admit		40% after ded	
Outpatient Services								
Outpatient Facility	\$200 after ded		\$200 after ded		\$250		40% after ded	
Lab/X-Ray	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		Lab-No charge/50% after ded (D/ND); X-ray-40% after ded	
Mental Health Outpatient	\$40 ded waived		\$40 ded waived		\$100		\$80 ded waived	
Emergency Care								
Emergency Room	\$500 (waived if admitted) ded waived		\$500 (waived if admitted) ded waived		\$1,500 (waived if admitted)		50% after ded	
Urgent Care	\$75 ded waived		\$75 ded waived		\$100		\$100 ded waived	
Single	2 x	\$1,212.65	2 x	\$1,170.35	2 x	\$1,149.62	2 x	\$1,018.13
EE with Spouse	0 x	\$2,425.30	0 x	\$2,340.70	0 x	\$2,299.25	0 x	\$2,036.26
EE with Child(ren)	0 x	\$2,061.51	0 x	\$1,989.59	0 x	\$1,954.36	0 x	\$1,730.82
Family	0 x	\$3,456.06	0 x	\$3,335.50	0 x	\$3,276.42	0 x	\$2,901.67
Monthly Cost	2	\$2,425.30	2	\$2,340.70	2	\$2,299.24	2	\$2,036.26
Annual Cost		\$29,103.60		\$28,088.40		\$27,590.88		\$24,435.12

Prepared For: **Oxford 2025 4th Qtr Metro New York City**
New York County, NY 10001
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Health Plan Comparison Report (4L)
Effective Date: 10/01/2025 Prepared On: 08/21/2025
Report ID: 39260851 SIC: 6411

	Oxford Metro NY S MTRO GT 30/80/3750/60 EPO 25 CNT (EPOc) (UCR=N/A)		Oxford Metro NY S MTRO GT 35/50/4000/70 EPO HSA 25 CNT (HSA) (UCR=N/A)		Oxford Metro NY B MTRO GT 7250/100 EPO HSA 25 CNT (HSA) (UCR=N/A)		Oxford Metro NY B MTRO GT 40/75/6500/50 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	10/65/95/200 ded T2-3		10/65/50%to\$800 IntDed		0%/0%/0% IntDed		10/40/80 IntDed	
Cost Share Information								
Individual/Family Deductible	\$3,750/\$7,500		\$4,000/\$8,000		\$7,250/\$14,500		\$6,500/\$13,000	
Individual/Family OOP Limit	\$9,200/\$18,400 (incl ded)		\$7,200/\$14,400 (incl ded)		\$7,250/\$14,500 (incl ded)		\$8,000/\$16,000 (incl ded)	
Co-Insurance	40%		30%		0%		50%	
Office Visits								
Primary Care	\$30 ded waived		\$35 after ded		0% after ded		\$40 after ded	
Specialist	\$80 ded waived		\$50 after ded		0% after ded		\$75 after ded	
Inpatient Services								
Inpatient Hospital	40% after ded		30% after ded		0% after ded		50% after ded	
Mental Health Inpatient	40% after ded		30% after ded		0% after ded		50% after ded	
Outpatient Services								
Outpatient Facility	40% after ded		\$300 after ded		0% after ded		\$500 after ded	
Lab/X-Ray	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		Lab-\$15 after ded; X-ray-50% after ded	
Mental Health Outpatient	\$80 ded waived		\$50 after ded		0% after ded		\$75 after ded	
Emergency Care								
Emergency Room	50% after ded		\$500 (waived if admitted) after ded		0% after ded		\$500 (waived if admitted) after ded	
Urgent Care	\$100 ded waived		\$100 after ded		0% after ded		\$100 after ded	
Single	2 x	\$982.62	2 x	\$952.80	2 x	\$902.67	2 x	\$884.83
EE with Spouse	0 x	\$1,965.25	0 x	\$1,905.61	0 x	\$1,805.35	0 x	\$1,769.66
EE with Child(ren)	0 x	\$1,670.46	0 x	\$1,619.76	0 x	\$1,534.55	0 x	\$1,504.21
Family	0 x	\$2,800.47	0 x	\$2,715.49	0 x	\$2,572.63	0 x	\$2,521.76
Monthly Cost	2	\$1,965.24	2	\$1,905.60	2	\$1,805.34	2	\$1,769.66
Annual Cost		\$23,582.88		\$22,867.20		\$21,664.08		\$21,235.92

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