Prepared For: **Oxford 2026 1st qtr Freedom NY City**

New York County, NY 10001

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

Health Plan Comparison Report (4L)

Effective Date: 01/01/2026 Prepared On: 10/22/2025

Report ID: 39277464 SIC: 8721

	Oxford Freedom NY P FRDM NG 20/40/100 PPO FAIR 26 CNT (PPO) (UCR=80fh%)		Oxford Freedom NY P FRDM NG 5/15/100 PPO 26 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 20/40/100 PPO 26 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 5/15/100 EPO 26 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 $2,313.80		2 x $1,735.81		2 x $1,703.99		2 x $1,693.33	
EE with Spouse	0 x $4,627.60		0 x $3,471.61		0 x $3,407.98		0 x $3,386.67	
EE with Child(ren)	0 x $3,933.46		0 x $2,950.87		0 x $2,896.79		0 x $2,878.67	
Family	0 x $6,594.33		0 x $4,947.04		0 x $4,856.38		0 x $4,826.00	
Monthly Cost	2 $4,627.60		2 $3,471.62		2 $3,407.98		2 $3,386.66	
Annual Cost	$55,531.20		$41,659.44		$40,895.76		$40,639.92	

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

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	Oxford Freedom NY P FRDM NG 15/25/100 EPO 26 CNT (EPO) (UCR=N/A)		Oxford Freedom NY P FRDM NG 20/40/100 EPO 26 CNT (EPO) (UCR=N/A)		Oxford Freedom NY P FRDM NG 10/25/250/90 EPO 26 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/50/100 EPO ZD 26 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)		$7,300/$14,600	
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		$400/admit		10% after ded		$500/admit	
Outpatient Services								
Outpatient Facility	$100		$300		10% after ded		Refer to carrier	
Lab/X-Ray	Lab-No charge/$60 (D/ND); X-ray-$20		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 $1,670.21		2 x $1,663.87		2 x $1,616.89		2 x $1,517.10	
EE with Spouse	0 x $3,340.43		0 x $3,327.75		0 x $3,233.79		0 x $3,034.21	
EE with Child(ren)	0 x $2,839.36		0 x $2,828.58		0 x $2,748.72		0 x $2,579.08	
Family	0 x $4,760.11		0 x $4,742.04		0 x $4,608.14		0 x $4,323.75	
Monthly Cost	2 $3,340.42		2 $3,327.74		2 $3,233.78		2 $3,034.20	
Annual Cost	$40,085.04		$39,932.88		$38,805.36		$36,410.40	

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

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	Oxford Freedom NY G FRDM NG 25/40/1500/80 PPO 26 CNT (PPOc) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 50/50/1000/90 EPO 26 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 15/35/1750/90 EPO 26 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/40/1750/80 EPO 26 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 $1,474.35		2 x $1,451.59		2 x $1,438.95		2 x $1,431.77	
EE with Spouse	0 x $2,948.69		0 x $2,903.18		0 x $2,877.91		0 x $2,863.54	
EE with Child(ren)	0 x $2,506.39		0 x $2,467.71		0 x $2,446.22		0 x $2,434.01	
Family	0 x $4,201.89		0 x $4,137.03		0 x $4,101.02		0 x $4,080.54	
Monthly Cost	2 $2,948.70		2 $2,903.18		2 $2,877.90		2 $2,863.54	
Annual Cost	$35,384.40		$34,838.16		$34,534.80		$34,362.48	

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

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	Oxford Freedom NY G FRDM NG 1700/90 PPO HSA 26 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 30/60/2250/70 EPO 26 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 1700/90 EPO HSA 26 CNT (HSA) (UCR=N/A)		Oxford Freedom NY S FRDM NG 50/100/100 EPO ZD 26 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	10/40/80 IntDed		10/40/80/150 ded T2-3		10/40/80 IntDed		15/65/95/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$1,700/$3,400	$4,000/$8,000	$2,250/$4,500		$1,700/$3,400		N/A	
Individual/Family OOP Limit	$5,750/$11,500 (incl ded)	$10,500/$21,000 (incl ded)	$7,250/$14,500 (incl ded)		$5,750/$11,500 (incl ded)		$9,300/$18,600	
Co-Insurance	10%	40%	30%		10%		0%	
Office Visits								
Primary Care	10% after ded	40% after ded	$30 ded waived		10% after ded		$50	
Specialist	10% after ded	40% after ded	$60 ded waived		10% after ded		$100	
Inpatient Services								
Inpatient Hospital	10% after ded	40% after ded	30% after ded		10% after ded		$1,500/admit	
Mental Health Inpatient	10% after ded	40% after ded	30% after ded		10% after ded		$1,500/admit	
Outpatient Services								
Outpatient Facility	10% after ded	40% after ded	30% after ded		10% after ded		Refer to carrier	
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		10% after ded		Lab-No charge/$60 (D/ND); X-ray-$200	
Mental Health Outpatient	10% after ded	40% after ded	$60 ded waived		10% after ded		$100	
Emergency Care								
Emergency Room	50% after ded	Paid as in-network	$500 (waived if admitted) ded waived		50% after ded		$1,500 (waived if admitted)	
Urgent Care	10% after ded	40% after ded	$75 ded waived		10% after ded		$100	
Single	2 x $1,394.60		2 x $1,384.85		2 x $1,360.68		2 x $1,352.83	
EE with Spouse	0 x $2,789.21		0 x $2,769.70		0 x $2,721.36		0 x $2,705.65	
EE with Child(ren)	0 x $2,370.83		0 x $2,354.25		0 x $2,313.16		0 x $2,299.81	
Family	0 x $3,974.62		0 x $3,946.82		0 x $3,877.94		0 x $3,855.55	
Monthly Cost	2 $2,789.20		2 $2,769.70		2 $2,721.36		2 $2,705.66	
Annual Cost	$33,470.40		$33,236.40		$32,656.32		$32,467.92	

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

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	Oxford Freedom NY G FRDM NG 2200/100 EPO HSA PR 26 CNT (HSA) (UCR=N/A)		Oxford Freedom NY S FRDM NG 40/80/3250/60 PPO 26 CNT (PPOc) (UCR=140mc%)		Oxford Freedom NY S FRDM NG 30/60/2350/70 PPO HSA 26 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY S FRDM NG 40/80/3250/60 EPO 26 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 IntDed		10/50/90/200 ded T2-3		10/40/80 IntDed		10/50/90/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$2,200/$4,400		$3,250/$6,500	$6,000/$12,000	$2,350/$4,700	$6,000/$12,000	$3,250/$6,500	
Individual/Family OOP Limit	$8,300/$16,600 (incl ded)		$9,200/$18,400 (incl ded)	$15,500/$31,000 (incl ded)	$8,300/$16,600 (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	0% after ded		$40 ded waived	50% after ded	$30 after ded	50% after ded	$40 ded waived	
Specialist	0% after ded		$80 ded waived	50% after ded	$60 after ded	50% after ded	$80 ded waived	
Inpatient Services								
Inpatient Hospital	0% after ded		40% after ded	50% after ded	30% after ded	50% after ded	40% after ded	
Mental Health Inpatient	0% after ded		40% after ded	50% after ded	30% after ded	50% after ded	40% after ded	
Outpatient Services								
Outpatient Facility	0% after ded		40% after ded	50% after ded	$150 after ded	50% after ded; pre-auth req	40% after ded	
Lab/X-Ray	0% after ded		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	0% after ded		$80 ded waived	50% after ded	$60 after ded	50% after ded	$80 ded waived	
Emergency Care								
Emergency Room	50% after ded		50% after ded	Paid as in-network	50% after ded	Paid as in-network	50% after ded	
Urgent Care	0% after ded		$100 ded waived	50% after ded	$100 after ded	50% after ded	$100 ded waived	
Single	2 x $1,352.30		2 x $1,252.20		2 x $1,233.91		2 x $1,221.01	
EE with Spouse	0 x $2,704.60		0 x $2,504.39		0 x $2,467.83		0 x $2,442.02	
EE with Child(ren)	0 x $2,298.90		0 x $2,128.74		0 x $2,097.65		0 x $2,075.71	
Family	0 x $3,854.05		0 x $3,568.76		0 x $3,516.65		0 x $3,479.87	
Monthly Cost	2 $2,704.60		2 $2,504.40		2 $2,467.82		2 $2,442.02	
Annual Cost	$32,455.20		$30,052.80		$29,613.84		$29,304.24	

 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 26 CNT (HSA) (UCR=N/A)		Oxford Freedom NY S FRDM NG 2500/60 EPO HSA 26 CNT (HSA) (UCR=N/A)		Oxford Freedom NY B FRDM NG 30/60/6750/80 PPO HSA 26 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY B FRDM NG 5000/50 EPO HSA 26 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	$7,350/$14,700 (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 $1,215.34		2 x $1,178.44		2 x $1,117.51		2 x $1,105.48	
EE with Spouse	0 x $2,430.67		0 x $2,356.88		0 x $2,235.02		0 x $2,210.96	
EE with Child(ren)	0 x $2,066.07		0 x $2,003.35		0 x $1,899.77		0 x $1,879.32	
Family	0 x $3,463.71		0 x $3,358.55		0 x $3,184.90		0 x $3,150.62	
Monthly Cost	2 $2,430.68		2 $2,356.88		2 $2,235.02		2 $2,210.96	
Annual Cost	$29,168.16		$28,282.56		$26,820.24		$26,531.52	

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