

	Oxford Freedom NY P FRDM NG 20/40/100 PPO FAIR 27 CNT (PPO) (UCR=80fh%)		Oxford Freedom NY P FRDM NG 5/15/100 PPO 27 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 20/40/100 PPO 27 CNT (PPO) (UCR=140mc%)		Oxford Freedom NY P FRDM NG 5/15/100 EPO 27 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)	\$4,750/\$9,500	\$6,500/\$13,000 (incl ded)	\$3,250/\$6,500	\$8,000/\$16,000 (incl ded)	\$4,750/\$9,500	
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	\$200	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	\$300 (waived if admitted)	Paid as in-network	\$300 (waived if admitted)	Paid as in-network	\$300 (waived if admitted)	Paid as in-network	\$300 (waived if admitted)	
Urgent Care	\$50	20% after ded	\$50	30% after ded	\$50	30% after ded	\$50	
Single	2 x	\$2,564.99	2 x	\$1,882.77	2 x	\$1,853.31	2 x	\$1,833.82
EE with Spouse	0 x	\$5,129.99	0 x	\$3,765.54	0 x	\$3,706.63	0 x	\$3,667.63
EE with Child(ren)	0 x	\$4,360.49	0 x	\$3,200.71	0 x	\$3,150.63	0 x	\$3,117.49
Family	0 x	\$7,310.23	0 x	\$5,365.90	0 x	\$5,281.95	0 x	\$5,226.38
Monthly Cost	2	\$5,129.98	2	\$3,765.54	2	\$3,706.62	2	\$3,667.64
Annual Cost		\$61,559.76		\$45,186.48		\$44,479.44		\$44,011.68

	Oxford Freedom NY P FRDM NG 15/25/100 EPO 27 CNT (EPO) (UCR=N/A)		Oxford Freedom NY P FRDM NG 20/40/100 EPO 27 CNT (EPO) (UCR=N/A)		Oxford Freedom NY P FRDM NG 10/25/250/90 EPO 27 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/50/100 EPO ZD 27 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		10/65/95/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		N/A		\$250/\$500		N/A	
Individual/Family OOP Limit	\$3,750/\$7,500		\$3,250/\$6,500		\$3,750/\$7,500 (incl ded)		\$10,000/\$20,000	
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		\$750/admit	
Mental Health Inpatient	\$200/day; \$800 max/admit		\$400/admit		10% after ded		\$750/admit	
Outpatient Services								
Outpatient Facility	\$100		\$300		10% after ded		\$300	
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		\$25	
Emergency Care								
Emergency Room	\$300 (waived if admitted)		\$300 (waived if admitted)		50% after ded		\$1,000 (waived if admitted)	
Urgent Care	\$50		\$50		\$50 ded waived		\$75	
Single	2 x	\$1,813.00	2 x	\$1,806.43	2 x	\$1,736.87	2 x	\$1,633.70
EE with Spouse	0 x	\$3,626.00	0 x	\$3,612.86	0 x	\$3,473.75	0 x	\$3,267.39
EE with Child(ren)	0 x	\$3,082.10	0 x	\$3,070.93	0 x	\$2,952.68	0 x	\$2,777.29
Family	0 x	\$5,167.05	0 x	\$5,148.33	0 x	\$4,950.09	0 x	\$4,656.03
Monthly Cost	2	\$3,626.00	2	\$3,612.86	2	\$3,473.74	2	\$3,267.40
Annual Cost		\$43,512.00		\$43,354.32		\$41,684.88		\$39,208.80

	Oxford Freedom NY G FRDM NG 25/40/1500/80 PPO 27 CNT (PPOc) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 50/50/1000/90 EPO 27 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 15/35/1750/90 EPO 27 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 25/40/1750/80 EPO 27 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	\$7,750/\$15,500 (incl ded)	\$10,500/\$21,000 (incl ded)	\$7,150/\$14,300 (incl ded)		\$9,000/\$18,000 (incl ded)		\$7,000/\$14,000 (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; \$2,500 max/admit		10% after ded		20% after ded	
Mental Health Inpatient	20% after ded	40% after ded	\$250/day after ded; \$2,500 max/admit		10% after ded		20% after ded	
Outpatient Services								
Outpatient Facility	\$200 after ded	40% after ded; pre-auth req	\$200 after ded		\$200 after ded		\$200 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	\$600 (waived if admitted) ded waived	Paid as in-network	\$600 (waived if admitted) ded waived		\$600 (waived if admitted) ded waived		\$600 (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	\$1,598.89	2 x	\$1,572.38	2 x	\$1,556.90	2 x	\$1,549.70
EE with Spouse	0 x	\$3,197.78	0 x	\$3,144.75	0 x	\$3,113.80	0 x	\$3,099.41
EE with Child(ren)	0 x	\$2,718.12	0 x	\$2,673.04	0 x	\$2,646.73	0 x	\$2,634.50
Family	0 x	\$4,556.84	0 x	\$4,481.28	0 x	\$4,437.17	0 x	\$4,416.66
Monthly Cost	2	\$3,197.78	2	\$3,144.76	2	\$3,113.80	2	\$3,099.40
Annual Cost		\$38,373.36		\$37,737.12		\$37,365.60		\$37,192.80

	Oxford Freedom NY G FRDM NG 15/30/1800/100 PPO HSA 27 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 1750/90 PPO HSA 27 CNT (HSA) (UCR=140mc%)		Oxford Freedom NY G FRDM NG 30/60/2250/70 EPO 27 CNT (EPOc) (UCR=N/A)		Oxford Freedom NY G FRDM NG 15/30/1800/100 EPO HSA 27 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	10/50/90 IntDed		10/40/80 IntDed		10/40/80/150 ded T2-3		10/50/90 IntDed	
Cost Share Information								
Individual/Family Deductible	\$1,800/\$3,600	\$10,000/\$20,000	\$1,750/\$3,500	\$4,000/\$8,000	\$2,250/\$4,500		\$1,800/\$3,600	
Individual/Family OOP Limit	\$5,500/\$8,900 (incl ded)	\$20,000/\$40,000 (incl ded)	\$6,000/\$12,000 (incl ded)	\$10,500/\$21,000 (incl ded)	\$7,250/\$14,500 (incl ded)		\$5,500/\$8,900 (incl ded)	
Co-Insurance	0%	50%	10%	40%	30%		0%	
Office Visits								
Primary Care	\$15 after ded	50% after ded	10% after ded	40% after ded	\$30 ded waived		\$15 after ded	
Specialist	\$30 after ded	50% after ded	10% after ded	40% after ded	\$60 ded waived		\$30 after ded	
Inpatient Services								
Inpatient Hospital	\$1,200/admit after ded	50% after ded	10% after ded	40% after ded	30% after ded		\$1,200/admit after ded	
Mental Health Inpatient	\$1,200/admit after ded	50% after ded	10% after ded	40% after ded	30% after ded		\$1,200/admit after ded	
Outpatient Services								
Outpatient Facility	\$800 after ded	50% after ded	10% after ded	40% after ded	30% after ded		\$800 after ded	
Lab/X-Ray	Lab-\$40 after ded; X-ray-\$100 after ded	Lab-Not covered; X-ray-50% after ded	10% after ded	Lab-Not covered; X-ray-40% after ded	Lab-No charge/50% after ded (D/ND); X-ray-30% after ded		Lab-\$40 after ded; X-ray-\$100 after ded	
Mental Health Outpatient	\$30 after ded	50% after ded	10% after ded	40% after ded	\$60 ded waived		\$30 after ded	
Emergency Care								
Emergency Room	\$500 (waived if admitted) after ded	Paid as in-network	50% after ded	Paid as in-network	\$600 (waived if admitted) ded waived		\$500 (waived if admitted) after ded	
Urgent Care	\$50 after ded	50% after ded	10% after ded	40% after ded	\$75 ded waived		\$50 after ded	
Single	2 x	\$1,523.84	2 x	\$1,516.70	2 x	\$1,503.31	2 x	\$1,493.52
EE with Spouse	0 x	\$3,047.68	0 x	\$3,033.40	0 x	\$3,006.62	0 x	\$2,987.05
EE with Child(ren)	0 x	\$2,590.53	0 x	\$2,578.39	0 x	\$2,555.62	0 x	\$2,538.99
Family	0 x	\$4,342.95	0 x	\$4,322.59	0 x	\$4,284.43	0 x	\$4,256.54
Monthly Cost	2	\$3,047.68	2	\$3,033.40	2	\$3,006.62	2	\$2,987.04
Annual Cost		\$36,572.16		\$36,400.80		\$36,079.44		\$35,844.48

Prepared For: **Oxford 2027 1st qtr Freedom Nassau Suffolk**
Nassau County, NY 11565
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Health Plan Comparison Report (4L)
Effective Date: 01/01/2027 Prepared On: 10/16/2026
Report ID: 39367019 SIC: 7372

	Oxford Freedom NY S FRDM NG 50/100/100 EPO ZD 27 CNT (EPO) (UCR=N/A)		Oxford Freedom NY S FRDM NG 40/80/3250/60 PPO 27 CNT (PPOc) (UCR=140mc%)		Oxford Freedom NY S FRDM NG 40/80/3250/60 EPO 27 CNT (EPOc) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs						
Drug Card	15/65/95/200 ded T2-3		10/50/90/200 ded T2-3		10/50/90/200 ded T2-3	
Cost Share Information						
Individual/Family Deductible	N/A		\$3,250/\$6,500	\$6,000/\$12,000	\$3,250/\$6,500	
Individual/Family OOP Limit	\$12,000/\$24,000		\$10,600/\$21,200 (incl ded)	\$15,500/\$31,000 (incl ded)	\$10,600/\$21,200 (incl ded)	
Co-Insurance	0%		40%	50%	40%	
Office Visits						
Primary Care	\$50		\$40 ded waived	50% after ded	\$40 ded waived	
Specialist	\$100		\$80 ded waived	50% after ded	\$80 ded waived	
Inpatient Services						
Inpatient Hospital	\$2,000/admit		40% after ded	50% after ded	40% after ded	
Mental Health Inpatient	\$2,000/admit		40% after ded	50% after ded	40% after ded	
Outpatient Services						
Outpatient Facility	\$500		40% after ded	50% after ded	40% after ded	
Lab/X-Ray	Lab-No charge/\$60 (D/ND); X-ray-\$200		Lab-No charge/50% after ded (D/ND); X-ray-40% 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	\$50		\$80 ded waived	50% after ded	\$80 ded waived	
Emergency Care						
Emergency Room	\$1,850 (waived if admitted)		50% after ded	Paid as in-network	50% after ded	
Urgent Care	\$100		\$100 ded waived	50% after ded	\$100 ded waived	
Single	2 x	\$1,450.69	2 x	\$1,345.55	2 x	\$1,309.08
EE with Spouse	0 x	\$2,901.37	0 x	\$2,691.11	0 x	\$2,618.16
EE with Child(ren)	0 x	\$2,466.17	0 x	\$2,287.44	0 x	\$2,225.44
Family	0 x	\$4,134.46	0 x	\$3,834.83	0 x	\$3,730.88
Monthly Cost	2	\$2,901.38	2	\$2,691.10	2	\$2,618.16
Annual Cost		\$34,816.56		\$32,293.20		\$31,417.92

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