

	Empire PPO/EPO Platinum EPO 5/25 0% 6SSC (EPO) (UCR=N/A)		Empire PPO/EPO Platinum EPO 20/40 0% 6SN6 (EPO) (UCR=N/A)		Empire PPO/EPO Gold EPO 25/50 0% 6SRM (EPO) (UCR=N/A)		Empire PPO/EPO Silver PPO 20/50 3000 30% w/HSA 6SMV (HSA) (UCR=140mc%)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	10/35/70/100 ded T2-3		10/35/70/100 ded T2-3		10/40/80/150 ded T2-3		10/50/90 IntDed	
Cost Share Information								
Individual/Family Deductible	N/A		N/A		N/A		\$3,000/\$6,000 embedded	\$7,000/\$14,000 embedded
Individual/Family OOP Limit	\$3,500/\$7,000		\$2,750/\$5,500		\$8,500/\$17,000		\$7,450/\$14,900 (incl ded)	\$18,625/\$37,250 (incl ded)
Co-Insurance	0%		0%		0%		30%	30%
Office Visits								
Primary Care	\$5		\$20		\$25		\$20 after ded	30% after ded
Specialist	\$25		\$40		\$50		\$50 after ded	30% after ded
Inpatient Services								
Inpatient Hospital	\$400/admit		\$500/admit		\$500/admit		\$1,500/admit after ded	30% after ded
Mental Health Inpatient	\$400/admit		\$500/admit		\$500/admit		\$1,500/admit after ded	30% after ded
Outpatient Services								
Outpatient Facility	\$300		\$500		\$500		\$500 after ded	30% after ded
Lab/X-Ray	Lab: No charge; X-ray: Office-\$50; OP-\$150		Lab: No charge; X-ray: Office-\$50; OP-\$150		Lab: No charge; X-ray: Office-\$50; OP-\$150		Lab: \$25 after ded; X-ray: Office-\$50 after ded; OP-\$150 after ded	30% after ded
Mental Health Outpatient	\$5		\$20		\$25		\$20 after ded	30% after ded
Emergency Care								
Emergency Room	\$300		\$300		\$750		\$500 after ded	Paid as in-network
Urgent Care	\$75		\$50		\$50		\$100 after ded	Paid as in-network
Single	2 x \$1,159.74		2 x \$1,152.57		2 x \$1,045.09		2 x \$1,041.65	
EE with Spouse	0 x \$2,319.48		0 x \$2,305.14		0 x \$2,090.18		0 x \$2,083.30	
EE with Child(ren)	0 x \$1,971.56		0 x \$1,959.37		0 x \$1,776.65		0 x \$1,770.81	
Family	0 x \$3,305.26		0 x \$3,284.82		0 x \$2,978.51		0 x \$2,968.70	
Monthly Cost	2 \$2,319.48		2 \$2,305.14		2 \$2,090.18		2 \$2,083.30	
Annual Cost	\$27,833.76		\$27,661.68		\$25,082.16		\$24,999.60	

	Empire PPO/EPO Gold EPO 30/55 1000 10% 6SMZ (EPOc) (UCR=N/A)		Empire PPO/EPO Gold EPO 15/35 1750 10% 6SNT (EPOc) (UCR=N/A)		Empire PPO/EPO Gold EPO 25/45 1750 20% 6SRV (EPOc) (UCR=N/A)		Empire PPO/EPO Gold EPO 20/50 1500 10% w/HSA WH 6SRX (HSA) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	10/40/80/150 ded T2-3		10/40/80/150 ded T2-3		10/40/80/150 ded T2-3		10/40/80 IntDed	
Cost Share Information								
Individual/Family Deductible	\$1,000/\$2,000 embedded		\$1,750/\$3,500 embedded		\$1,750/\$3,500 embedded		\$1,500/\$3,000 non-embedded	
Individual/Family OOP Limit	\$6,750/\$13,500 (incl ded)		\$8,500/\$17,000 (incl ded)		\$6,000/\$12,000 (incl ded)		\$5,000/\$10,000 (incl ded)	
Co-Insurance	10%		10%		20%		10%	
Office Visits								
Primary Care	\$30 ded waived		\$15 ded waived		\$25 ded waived		\$20 after ded	
Specialist	\$55 ded waived		\$35 ded waived		\$45 ded waived		\$50 after ded	
Inpatient Services								
Inpatient Hospital	10% after ded		10% after ded		20% after ded		\$1,000/admit after ded	
Mental Health Inpatient	10% after ded		10% after ded		20% after ded		\$1,000/admit after ded	
Outpatient Services								
Outpatient Facility	\$300 after ded		\$300 after ded		\$250 after ded		\$500 after ded	
Lab/X-Ray	Lab: No charge; X-ray: Office-\$50 after ded; OP-\$150 after ded		Lab: No charge; X-ray: Office-\$50 after ded; OP-\$150 after ded		Lab: No charge; X-ray: Office-\$50 after ded; OP-\$150 after ded		Lab: \$25 after ded; X-ray: Office-\$50 after ded; OP-\$150 after ded	
Mental Health Outpatient	\$30 ded waived		\$15 ded waived		\$25 ded waived		\$20 after ded	
Emergency Care								
Emergency Room	\$500 after ded		\$500 after ded		\$500 after ded		\$500 after ded	
Urgent Care	\$60 ded waived		\$60 ded waived		\$60 ded waived		\$100 after ded	
Single	2 x \$1,004.41		2 x \$979.89		2 x \$978.58		2 x \$968.89	
EE with Spouse	0 x \$2,008.82		0 x \$1,959.78		0 x \$1,957.16		0 x \$1,937.78	
EE with Child(ren)	0 x \$1,707.50		0 x \$1,665.81		0 x \$1,663.59		0 x \$1,647.11	
Family	0 x \$2,862.57		0 x \$2,792.69		0 x \$2,788.95		0 x \$2,761.34	
Monthly Cost	2 \$2,008.82		2 \$1,959.78		2 \$1,957.16		2 \$1,937.78	
Annual Cost	\$24,105.84		\$23,517.36		\$23,485.92		\$23,253.36	

	Empire PPO/EPO Gold EPO 35/60 2250 30% 6SMC (EPOc) (UCR=N/A)		Empire PPO/EPO Gold EPO 20/50 1500 10% w/HSA 6SM4 (HSA) (UCR=N/A)		Empire PPO/EPO Silver EPO 20/50 3000 25% w/HSA 6SMT (HSA) (UCR=N/A)		Empire PPO/EPO Silver EPO 40/70 3000 50% 6SPF (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 IntDed		10/50/90 IntDed		25/75/90/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	\$2,250/\$4,500 embedded		\$1,500/\$3,000 non-embedded		\$3,000/\$6,000 embedded		\$3,000/\$6,000 embedded	
Individual/Family OOP Limit	\$7,000/\$14,000 (incl ded)		\$5,000/\$10,000 (incl ded)		\$7,450/\$14,900 (incl ded)		\$9,100/\$18,200 (incl ded)	
Co-Insurance	30%		10%		25%		50%	
Office Visits								
Primary Care	\$35 ded waived		\$20 after ded		\$20 after ded		\$40 ded waived	
Specialist	\$60 ded waived		\$50 after ded		\$50 after ded		\$70 ded waived	
Inpatient Services								
Inpatient Hospital	30% after ded		\$1,000/admit after ded		\$1,500/admit after ded		50% after ded	
Mental Health Inpatient	30% after ded		\$1,000/admit after ded		\$1,500/admit after ded		50% after ded	
Outpatient Services								
Outpatient Facility	\$300 after ded		\$500 after ded		\$500 after ded		50% after ded	
Lab/X-Ray	Lab: No charge; X-ray: Office-\$50 after ded; OP-\$150 after ded		Lab: \$25 after ded; X-ray: Office-\$50 after ded; OP-\$150 after ded		Lab: \$25 after ded; X-ray: Office-\$50 after ded; OP-\$150 after ded		Lab: Office-\$20 ded waived; OP-\$25 ded waived; X-ray: Office-\$75 after ded; OP-50% after ded	
Mental Health Outpatient	\$35 ded waived		\$20 after ded		\$20 after ded		\$40 ded waived	
Emergency Care								
Emergency Room	\$500 after ded		\$500 after ded		\$500 after ded		50% after ded	
Urgent Care	\$75 ded waived		\$100 after ded		\$100 after ded		\$75 ded waived	
Single	2 x \$948.80		2 x \$947.79		2 x \$841.62		2 x \$839.90	
EE with Spouse	0 x \$1,897.60		0 x \$1,895.58		0 x \$1,683.24		0 x \$1,679.80	
EE with Child(ren)	0 x \$1,612.96		0 x \$1,611.24		0 x \$1,430.75		0 x \$1,427.83	
Family	0 x \$2,704.08		0 x \$2,701.20		0 x \$2,398.62		0 x \$2,393.72	
Monthly Cost	2 \$1,897.60		2 \$1,895.58		2 \$1,683.24		2 \$1,679.80	
Annual Cost	\$22,771.20		\$22,746.96		\$20,198.88		\$20,157.60	

Prepared For: **Empire 2023 4th qtr Albany EPO**

Albany County, NY 12007

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

Health Plan Comparison Report (4L)

Effective Date: 10/01/2023

Prepared On: 08/03/2023

Report ID: 38937548

SIC: 0000

	Empire PPO/EPO Silver EPO 20/50 3500 30% w/HSA 6SMR (HSA) (UCR=N/A)		Empire PPO/EPO Bronze EPO 20/50 6100 50% w/HSA 6SQB (HSA) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs				
Drug Card	10/50/90 IntDed		50%/50%/50% IntDed	
Cost Share Information				
Individual/Family Deductible	\$3,500/\$7,000 embedded		\$6,100/\$12,200 embedded	
Individual/Family OOP Limit	\$7,450/\$14,900 (incl ded)		\$7,450/\$14,900 (incl ded)	
Co-Insurance	30%		50%	
Office Visits				
Primary Care	\$20 after ded		\$20 after ded	
Specialist	\$50 after ded		\$50 after ded	
Inpatient Services				
Inpatient Hospital	\$1,500/admit after ded		\$1,000/admit after ded	
Mental Health Inpatient	\$1,500/admit after ded		\$1,000/admit after ded	
Outpatient Services				
Outpatient Facility	\$500 after ded		\$500 after ded	
Lab/X-Ray	Lab: \$25 after ded; X-ray: Office-\$50 after ded; OP- \$150 after ded		Lab: \$25 after ded; X-ray: Office-\$50 after ded; OP- \$150 after ded	
Mental Health Outpatient	\$20 after ded		\$20 after ded	
Emergency Care				
Emergency Room	\$500 after ded		\$500 after ded	
Urgent Care	\$100 after ded		\$100 after ded	
Single	2 x \$825.57		2 x \$747.35	
EE with Spouse	0 x \$1,651.14		0 x \$1,494.70	
EE with Child(ren)	0 x \$1,403.47		0 x \$1,270.50	
Family	0 x \$2,352.87		0 x \$2,129.95	
Monthly Cost	2 \$1,651.14		2 \$1,494.70	
Annual Cost	\$19,813.68		\$17,936.40	

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