Prepared For: **Anthem 2025 4th qtr EPO Albany**

Albany County, NY 12007

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

Health Plan Comparison Report (4L)

Effective Date: 10/01/2025 Prepared On: 08/21/2025

Report ID: 39260853 SIC: 0000

	Anthem PPO/EPO Platinum EPO 5/25 0% 8AES (EPO) (UCR=N/A)		Anthem PPO/EPO Platinum EPO 20/40 0% 8AFA (EPO) (UCR=N/A)		Anthem PPO/EPO Platinum EPO 15/35 300 10% 8AFB (EPOc) (UCR=N/A)		Anthem PPO/EPO Gold EPO 25/50 0% 8AF8 (EPO) (UCR=N/A)	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs								
Drug Card	10/35/70/100 ded T2-3		10/35/70/100 ded T2-3		10/50/90/200 ded T2-3		10/65/95/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		N/A		$300/$600 embedded		N/A	
Individual/Family OOP Limit	$3,900/$7,800		$3,500/$7,000		$3,200/$6,400 (incl ded)		$8,700/$17,400	
Co-Insurance	0%		0%		10%		0%	
Office Visits								
Primary Care	$5		$20		$15 ded waived		$25	
Specialist	$25		$40		$35 ded waived		$50	
Inpatient Services								
Inpatient Hospital	$400/admit		$500/admit		10% after ded		$500/admit	
Mental Health Inpatient	$400/admit		$500/admit		10% after ded		$500/admit	
Outpatient Services								
Outpatient Facility	Hospital-$300; ASC-$50		Hospital-$500; ASC-$100		Hospital-10% after ded; ASC-$50 after ded		Hospital-$500; ASC-$250	
Lab/X-Ray	Lab: No charge; X-ray: Office-$50; OP-$150		Lab: No charge; X-ray: Office-$50; OP-$150		Lab: Office-$20 ded waived; OP-$25 ded waived; X-ray: Office-$75 ded waived; OP-10% after ded		Lab: No charge; X-ray: Office-$50; OP-$150	
Mental Health Outpatient	No charge		No charge		No charge		No charge	
Emergency Care								
Emergency Room	$300		$300		10% after ded		$850	
Urgent Care	$50		$50		$50 ded waived		$75	
Single	2 x $1,338.01		2 x $1,325.71		2 x $1,299.08		2 x $1,203.70	
EE with Spouse	0 x $2,676.02		0 x $2,651.42		0 x $2,598.16		0 x $2,407.40	
EE with Child(ren)	0 x $2,274.62		0 x $2,253.71		0 x $2,208.44		0 x $2,046.29	
Family	0 x $3,813.33		0 x $3,778.27		0 x $3,702.38		0 x $3,430.55	
Monthly Cost	2 $2,676.02		2 $2,651.42		2 $2,598.16		2 $2,407.40	
Annual Cost	$32,112.24		$31,817.04		$31,177.92		$28,888.80	

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

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	Anthem PPO/EPO Gold EPO 50/60 1100 10% 8AE8 (EPOc) (UCR=N/A)		Anthem PPO/EPO Gold EPO 15/40 1850 15% 8AE6 (EPOc) (UCR=N/A)		Anthem PPO/EPO Gold EPO 25/45 1850 25% 8AEY (EPOc) (UCR=N/A)		Anthem PPO/EPO Gold EPO 20/40/50 2000 20% 8AET (EPOc) (UCR=N/A)	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs								
Drug Card	10/45/85/150 ded T2-3		10/40/80/200 ded T2-3		10/50/90/200 ded T2-3		10/20%/20% IntDed T2-3	
Cost Share Information								
Individual/Family Deductible	$1,100/$2,200 embedded		$1,850/$3,700 embedded		$1,850/$3,700 embedded		$2,000/$4,000 embedded	
Individual/Family OOP Limit	$7,000/$14,000 (incl ded)		$8,700/$17,400 (incl ded)		$7,250/$14,500 (incl ded)		$7,000/$14,000 (incl ded)	
Co-Insurance	10%		15%		25%		20%	
Office Visits								
Primary Care	$50 ded waived		$15 ded waived		$25 ded waived		$40 ded waived ($20 ded waived Preferred Provider)	
Specialist	$60 ded waived		$40 ded waived		$45 ded waived		$50 ded waived	
Inpatient Services								
Inpatient Hospital	10% after ded		15% after ded		25% after ded		20% after ded	
Mental Health Inpatient	10% after ded		15% after ded		25% after ded		20% after ded	
Outpatient Services								
Outpatient Facility	Hospital-$300 after ded; ASC-$150 after ded		Hospital-$300 after ded; ASC-$150 after ded		Hospital-$500 after ded; ASC-$150 after ded		Hospital-20% after ded; ASC-$200 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: Office-$50 ded waived; OP-20% after ded; X-ray: Office-$50 ded waived; OP-20% after ded	
Mental Health Outpatient	No charge		No charge		No charge		No charge	
Emergency Care								
Emergency Room	$750 after ded		$750 after ded		$750 after ded		40% after ded	
Urgent Care	$75 ded waived		$75 ded waived		$75 ded waived		$75 ded waived	
Single	2 x $1,145.85		2 x $1,119.23		2 x $1,113.67		2 x $1,085.12	
EE with Spouse	0 x $2,291.70		0 x $2,238.46		0 x $2,227.34		0 x $2,170.24	
EE with Child(ren)	0 x $1,947.95		0 x $1,902.69		0 x $1,893.24		0 x $1,844.70	
Family	0 x $3,265.67		0 x $3,189.81		0 x $3,173.96		0 x $3,092.59	
Monthly Cost	2 $2,291.70		2 $2,238.46		2 $2,227.34		2 $2,170.24	
Annual Cost	$27,500.40		$26,861.52		$26,728.08		$26,042.88	

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

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	Anthem PPO/EPO Gold EPO 20/50 1700 15% w/HSA PrevRx 8ADP (HSA) (UCR=N/A)		Anthem PPO/EPO Silver EPO 45/75 2600 30% 8AFK (EPOc) (UCR=N/A)		Anthem PPO/EPO Silver EPO 40/80 3350 50% 8AE2 (EPOc) (UCR=N/A)		Anthem PPO/EPO Silver EPO 40/80 4000 40% 8AFJ (EPOc) (UCR=N/A)	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs								
Drug Card	10/10%/10% IntDed		35/70/100/300 ded T2-3		25/75/90/200 ded T2-3		15/65/95/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	$1,700/$3,400 non-embedded		$2,600/$5,200 embedded		$3,350/$6,700 embedded		$4,000/$8,000 embedded	
Individual/Family OOP Limit	$5,950/$11,900 (incl ded)		$9,200/$18,400 (incl ded)		$9,200/$18,400 (incl ded)		$9,200/$18,400 (incl ded)	
Co-Insurance	15%		30%		50%		40%	
Office Visits								
Primary Care	$20 after ded		$45 ded waived		$40 ded waived		$40 ded waived	
Specialist	$50 after ded		$75 ded waived		$80 ded waived		$80 ded waived	
Inpatient Services								
Inpatient Hospital	15% after ded		30% after ded		50% after ded		40% after ded	
Mental Health Inpatient	15% after ded		30% after ded		50% after ded		40% after ded	
Outpatient Services								
Outpatient Facility	15% after ded		Hospital-$500 after ded; ASC-$300 after ded		Hospital-50% after ded; ASC-$300 after ded		Hospital-40% after ded; ASC-$500 after ded	
Lab/X-Ray	15% after ded		Lab: No charge; X-ray: Office-$50 after ded; OP-$150 after ded		Lab: Office-$20 ded waived; OP-$25 ded waived; X-ray: Office-$75 ded waived; OP-50% after ded		Lab: Office-$20 ded waived; OP-$25 ded waived; X-ray: Office-$75 ded waived; OP-40% after ded	
Mental Health Outpatient	0% after ded		No charge		No charge		No charge	
Emergency Care								
Emergency Room	15% after ded		$1,000 after ded		50% after ded		50% after ded	
Urgent Care	$100 after ded		$75 ded waived		$80 ded waived		$90 ded waived	
Single	2 x $1,070.58		2 x $1,007.27		2 x $981.93		2 x $981.61	
EE with Spouse	0 x $2,141.16		0 x $2,014.54		0 x $1,963.86		0 x $1,963.22	
EE with Child(ren)	0 x $1,819.99		0 x $1,712.36		0 x $1,669.28		0 x $1,668.74	
Family	0 x $3,051.15		0 x $2,870.72		0 x $2,798.50		0 x $2,797.59	
Monthly Cost	2 $2,141.16		2 $2,014.54		2 $1,963.86		2 $1,963.22	
Annual Cost	$25,693.92		$24,174.48		$23,566.32		$23,558.64	

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

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	Anthem PPO/EPO Silver EPO 35/65/90 5000 40% 8J4N (EPOc) (UCR=N/A)		Anthem PPO/EPO Silver EPO 20/50 3300 30% w/HSA PrevRx 8AGZ (HSA) (UCR=N/A)		Anthem PPO/EPO Silver EPO 20/50 4100 30% w/HSA PrevRx 8AGR (HSA) (UCR=N/A)		Anthem PPO/EPO Bronze EPO 20/50 6100 50% w/HSA 8AGS (HSA) (UCR=N/A)	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs								
Drug Card	15/40%/40% IntDed T2-3		10/30%/30% IntDed		10/50/90 IntDed		50%/50%/50% IntDed	
Cost Share Information								
Individual/Family Deductible	$5,000/$10,000 embedded		$3,300/$6,600 embedded		$4,100/$8,200 embedded		$6,100/$12,200 embedded	
Individual/Family OOP Limit	$9,000/$18,000 (incl ded)		$8,000/$16,000 (incl ded)		$8,000/$16,000 (incl ded)		$8,000/$16,000 (incl ded)	
Co-Insurance	40%		30%		30%		50%	
Office Visits								
Primary Care	$65 ded waived ($35 ded waived Preferred Provider)		$20 after ded		$20 after ded		$20 after ded	
Specialist	$90 ded waived		$50 after ded		$50 after ded		$50 after ded	
Inpatient Services								
Inpatient Hospital	40% after ded		30% after ded		30% after ded		50% after ded	
Mental Health Inpatient	40% after ded		30% after ded		30% after ded		50% after ded	
Outpatient Services								
Outpatient Facility	Hospital-40% after ded; ASC-$300 after ded		30% after ded		30% after ded		50% after ded	
Lab/X-Ray	Lab: Office-$90 ded waived; OP-40% after ded; X-ray: Office-$90 ded waived; OP-40% after ded		30% after ded		30% after ded		50% after ded	
Mental Health Outpatient	No charge		0% after ded		0% after ded		0% after ded	
Emergency Care								
Emergency Room	50% after ded		30% after ded		30% after ded		50% after ded	
Urgent Care	$85 ded waived		$100 after ded		$100 after ded		$100 after ded	
Single	2 x $938.63		2 x $906.33		2 x $889.44		2 x $851.48	
EE with Spouse	0 x $1,877.26		0 x $1,812.66		0 x $1,778.88		0 x $1,702.96	
EE with Child(ren)	0 x $1,595.67		0 x $1,540.76		0 x $1,512.05		0 x $1,447.52	
Family	0 x $2,675.10		0 x $2,583.04		0 x $2,534.90		0 x $2,426.72	
Monthly Cost	2 $1,877.26		2 $1,812.66		2 $1,778.88		2 $1,702.96	
Annual Cost	$22,527.12		$21,751.92		$21,346.56		$20,435.52	

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