2023 Health Plan Comparison Summary

	Option 1 – Empire PPO		Option 2 – Empire HSA Gold (formerly HSA)		Option 3 – Empire HSA Silver	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Copayments, Deductibles, and Coinsurance						
Copayments						
Primary Care	You pay $25 copay	N/A	N/A	N/A	N/A	N/A
Specialist Care	You pay $50 copay	N/A	N/A	N/A	N/A	N/A
Deductibles (Calendar Year)	Medical and Hospital	Medical and Hospital	Medical, Hospital and Prescriptions		Medical, Hospital and Prescriptions	
Individual	$250	$1,000	$1,500		$3,000	
Family	$500	$2,000	$3,000		$6,000	
	Claims applied toward the out-of-network deductible also apply toward the in-network deductible.		Family deductible must be met before any claims are paid for two-person or family coverage.		Family deductible must be met before any claims are paid for two-person or family coverage.	
Coinsurance *(after deductible)*	You pay 10%*	You pay 30%* of Allowed Amount	You pay 10%*	You pay 30%* of Allowed Amount	You pay 10%*	You pay 30%* of Allowed Amount
Allowed Amount *(Reasonable & Customary Charges)*	N/A	90th percentile	N/A	80th percentile	N/A	80th percentile
Lazard's Annual HSA Contribution (prorated based on enrollment date)						
Individual	N/A	N/A	Up to $1,000		Up to $1,000	
Family	N/A	N/A	Up to $2,000		Up to $2,000	
Annual Out-of-Pocket Maximums (includes deductibles) and Plan Lifetime Maximum						
Annual Out-of-Pocket Participant Maximums	includes copays					
Individual	$1,250	$4,000	$3,500	$7,000	$5,000	$10,000
Family	$2,500	$8,000	$7,000	$14,000	$10,000	$20,000
	Out-of-network coinsurance paid applies toward both the in-network and out-of-network out-of-pocket maximum.		Out-of-network coinsurance paid applies toward both the in-network and out-of-network out-of-pocket maximum. Family out-of-pocket maximum must be met before the plan pays at 100% for any individual family member.		Out-of-network coinsurance paid applies toward both the in-network and out-of-network out-of-pocket maximum. Family out-of-pocket maximum must be met before the plan pays at 100% for any individual family member.	
Plan Lifetime Maximum	None	None	None	None	None	None

Notes

Discounts apply when using network providers.

All plan deductibles, plan out-of-pocket maximums, and service specific maximums (dollar and occurrence) cross-accumulate between in-network and out-of-network unless otherwise noted.

All out-of-network coinsurance levels referenced throughout this document are subject to Empire's 'Allowed Amount', which refers to the maximum amount Empire will pay for a covered service. If your out-of-network provider charges more than the Allowed Amount, you must pay the difference between the Allowed Amount and the actual charge. Amounts that are in excess of the Allowed Amount do not apply toward your Out-of-Network Out-of-Pocket Maximum.

All inpatient hospital admissions require Pre-Admission Certification and Continued Stay Review. If your admission/continued stay is not authorized, benefits can be denied. Emergency inpatient admissions require certification within 48 hours of admission.

Telehealth visits with your own medical and mental health care providers via Skype, FaceTime, Zoom, etc. exclude procedures/codes that indicate physical hands-on evaluation, such as certain physical therapy codes, chiropractic services and acupuncture.

*These expenses are subject to the deductible.

2023 Health Plan Comparison Summary

	Option 1 – Empire PPO		Option 2 – Empire HSA Gold (formerly HSA)		Option 3 – Empire HSA Silver	
Medical Benefits	**In-Network.**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Preventive Care						
Annual Physical Exam	No Charge	You pay 30%*	No Charge	You pay 30%*	No Charge	You pay 30%*
Immunizations	No Charge	You pay 30%*	No Charge	You pay 30%*	No Charge	You pay 30%*
Well-Woman Care (ob/gyn)	No Charge	You pay 30%*	No Charge	You pay 30%*	No Charge	You pay 30%*
Well-Child Care (up to age 19)	No Charge	You pay 30%*	No Charge	You pay 30%*	No Charge	You pay 30%*
Providers (Physicians, Specialists & Surgeons)						
Primary Care Office Visits	You pay $25 copay	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Specialists	You pay $50 copay	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Urgent Care	You pay $50 copay	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Surgery	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Corrective Eye Surgery (LASIK, PRK, RK, etc.)	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Hospital Care						
Pre-Certification & Continued Stay Review	Required	Required	Required	Required	Required	Required
Inpatient Care (pre-certification required)	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Outpatient Care (surgical facility/pre-admission testing)	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Emergency Room (if deemed a true emergency)	You pay $100 copay (waived if admitted)	You pay $100 copay (waived if admitted)	You pay 10%*	You pay 10%*	You pay 10%*	You pay 10%*

Notes

Discounts apply when using network providers.

All plan deductibles, plan out-of-pocket maximums, and service specific maximums (dollar and occurrence) cross-accumulate between in-network and out-of-network unless otherwise noted.

All out-of-network coinsurance levels referenced throughout this document are subject to Empire's 'Allowed Amount', which refers to the maximum amount Empire will pay for a covered service. If your out-of-network provider charges more than the Allowed Amount, you must pay the difference between the Allowed Amount and the actual charge. Amounts that are in excess of the Allowed Amount do not apply toward your Out-of-Network Out-of-Pocket Maximum.

All inpatient hospital admissions require Pre-Admission Certification and Continued Stay Review. If your admission/continued stay is not authorized, benefits can be denied. Emergency inpatient admissions require certification within 48 hours of admission.

Telehealth visits with your own medical and mental health care providers via Skype, FaceTime, Zoom, etc. exclude procedures/codes that indicate physical hands-on evaluation, such as certain physical therapy codes, chiropractic services and acupuncture.

*These expenses are subject to the deductible.

2023 Health Plan Comparison Summary

	Option 1 – Empire PPO		Option 2 – Empire HSA Gold (formerly HSA)		Option 3 – Empire HSA Silver	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drugs (Exclusions may apply): Tier 1 (Typically Generic); Tier 2 (Typically Preferred Brand); Tier 3 (Typically Non-Preferred/Specialty Drugs						
Pharmacy (30-day supply)						
Tier 1	You pay $10 copay	In-network	You pay 10%*	In-network	You pay 10%*	In-network
Tier 2	You pay $50 copay	Coverage	You pay 10%*	Coverage	You pay 10%*	Coverage
Tier 3	You pay $70 copay	Only	You pay 10%*	Only	You pay 10%*	Only
Maintenance Drugs (90-day supply)	Empire Mail Order		Empire Mail Order		Empire Mail Order	
Tier 1	You pay $20 copay	In-network	You pay 10%*	In-network	You pay 10%*	In-network
Tier 2	You pay $100 copay	Coverage	You pay 10%*	Coverage	You pay 10%*	Coverage
Tier 3	You pay $140 copay	Only	You pay 10%*	Only	You pay 10%*	Only
Alcohol and Drug Treatment						
Inpatient Care (pre-certification required)	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Outpatient Care	You pay $25 copay	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Mental Health Care						
Inpatient Care (pre-certification required)	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Outpatient Care	You pay $25 copay	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*

Notes

Discounts apply when using network providers.

All plan deductibles, plan out-of-pocket maximums, and service specific maximums (dollar and occurrence) cross-accumulate between in-network and out-of-network unless otherwise noted.

All out-of-network coinsurance levels referenced throughout this document are subject to Empire's 'Allowed Amount', which refers to the maximum amount Empire will pay for a covered service. If your out-of-network provider charges more than the Allowed Amount, you must pay the difference between the Allowed Amount and the actual charge. Amounts that are in excess of the Allowed Amount do not apply toward your Out-of-Network Out-of-Pocket Maximum.

All inpatient hospital admissions require Pre-Admission Certification and Continued Stay Review. If your admission/continued stay is not authorized, benefits can be denied. Emergency inpatient admissions require certification within 48 hours of admission.

Telehealth visits with your own medical and mental health care providers via Skype, FaceTime, Zoom, etc. exclude procedures/codes that indicate physical hands-on evaluation, such as certain physical therapy codes, chiropractic services and acupuncture.

*These expenses are subject to the deductible.

2023 Health Plan Comparison Summary

	Option 1 – Empire PPO		Option 2 – Empire HSA Gold (formerly HSA)		Option 3 – Empire HSA Silver	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Other Covered Services						
Maternity Care Initial visit to determine pregnancy, pre and post-natal visits, and delivery charges	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Skilled Nursing Facility (pre-certification required)	You pay 10%* up to 60 days per year	In-Network Coverage Only	You pay 10%* up to 60 days per year	You pay 30%* up to 60 days per year	You pay 10%* up to 60 days per year	You pay 30%* up to 60 days per year
Home Health Care (pre-authorization and/or pre-certification may be required)	You pay 10%* up to 200 visits per year	You pay 30% up to 200 visits per year	You pay 10%* up to 200 visits per year	You pay 30%* up to 200 visits per year	You pay 10%* up to 200 visits per year	You pay 30%* up to 200 visits per year
Chiropractic Care (when medically necessary)	You pay $50 copay	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Physical Therapy** (Out-Patient) (up to 120 visits per year)	You pay $50 copay	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Physical Rehabilitation Facility (up to 60 days per year) (pre-certification required)	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Short-Term Therapies** (Speech/Language, Occupational, Vision) up to 120 visits each type per year	You pay $50 copay	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Durable Medical Equipment (pre-certification may be required)	You pay 10%*	In-Network Coverage Only	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*

Notes

Discounts apply when using network providers.

All plan deductibles, plan out-of-pocket maximums, and service specific maximums (dollar and occurrence) cross-accumulate between in-network and out-of-network unless otherwise noted.

All out-of-network coinsurance levels referenced throughout this document are subject to Empire's 'Allowed Amount', which refers to the maximum amount Empire will pay for a covered service. If your out-of-network provider charges more than the Allowed Amount, you must pay the difference between the Allowed Amount and the actual charge. Amounts that are in excess of the Allowed Amount do not apply toward your Out-of-Network Out-of-Pocket Maximum.

All inpatient hospital admissions require Pre-Admission Certification and Continued Stay Review. If your admission/continued stay is not authorized, benefits can be denied. Emergency inpatient admissions require certification within 48 hours of admission.

Telehealth visits with your own medical and mental health care providers via Skype, FaceTime, Zoom, etc. exclude procedures/codes that indicate physical hands-on evaluation, such as certain physical therapy codes, chiropractic services and acupuncture.

*These expenses are subject to the deductible.

**Visit limits for Physical Therapy, Occupational Therapy, or Speech Therapy do not apply when there is a mental health or substance abuse diagnosis.

2023 Health Plan Comparison Summary

Medical Benefits	Option 1 – Empire PPO In-Network	Option 1 – Empire PPO Out-of-Network	Option 2 – Empire HSA Gold (formerly HSA) In-Network	Option 2 – Empire HSA Gold (formerly HSA) Out-of-Network	Option 3 – Empire HSA Silver In-Network	Option 3 – Empire HSA Silver Out-of-Network
Reproductive Health						
Diagnosis, testing and surgical treatment of the underlying cause of infertility	You pay $50 copay	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Artificial Insemination Pre-certification by WINFertility is required.	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*	You pay 10%*	You pay 30%*
Comprehensive Infertility Coverage Pre-certification by WINFertility is required. Lifetime limit of 3 cycles for IVF; up to 3 cycles of GIFT or ZIFT only if IVF benefit has not been exhausted. Each covered cycle includes embryo storage for up to 12 months.	You pay 10%*	In-Network Coverage Only	You pay 10%*	In-Network Coverage Only	You pay 10%*	In-Network Coverage Only
Egg Freezing Fertility Benefit Pre-certification by WINFertility is required.	You pay $50 copay	In-Network Coverage Only	You pay 10%*	In-Network Coverage Only	You pay 10%*	In-Network Coverage Only
Egg Freezing Storage Benefit Every 12 months; No age limit	You pay 10%*	In-Network Coverage Only	You pay 10%*	In-Network Coverage Only	You pay 10%*	In-Network Coverage Only
Medical Travel Benefit** For reproductive services not available in the home state of the employee/dependent. Subject to IRS limits.	You pay 10%*	In-Network Coverage Only	You pay 10%*	In-Network Coverage Only	You pay 10%*	In-Network Coverage Only

Notes

Discounts apply when using network providers.

All plan deductibles, plan out-of-pocket maximums, and service specific maximums (dollar and occurrence) cross-accumulate between in-network and out-of-network unless otherwise noted.

All out-of-network coinsurance levels referenced throughout this document are subject to Empire's 'Allowed Amount', which refers to the maximum amount Empire will pay for a covered service. If your out-of-network provider charges more than the Allowed Amount, you must pay the difference between the Allowed Amount and the actual charge. Amounts that are in excess of the Allowed Amount do not apply toward your Out-of-Network Out-of-Pocket Maximum.

All inpatient hospital admissions require Pre-Admission Certification and Continued Stay Review. If your admission/continued stay is not authorized, benefits can be denied. Emergency inpatient admissions require certification within 48 hours of admission.

*These expenses are subject to the deductible.

**Send copies of your itemized receipts, completed claim form and any supporting documentation to: TravelandLodging@anthem.com.

2023 HEALTH PLAN COMPARISON SUMMARY

Vision Insurance

Your medical plan election includes vision coverage under the Vision Service Plan (VSP).

VISION SERVICE PLAN[1]

VISION BENEFITS	FREQUENCY[2]	VSP DOCTORS In-Network	NON-VSP DOCTORS Out-Of-Network
Exam	12 months	You pay $10 copay	You pay any amount over $50
Lenses[3]	12 months	You pay $20 copay (for lenses & frame)	You pay any amount over: $ 50/single vision $ 75/bifocal $100/trifocal $125/lenticular $ 5/tints
Frame[3]	12 months	You pay 80% of any amount over the $280 retail frame allowance.	You pay any amount over $70
Contact Lenses[4]		You pay $20 copay	
Medically Necessary[5]	12 months		You pay any amount over $210
Elective	12 months	You pay $60 copay	
Fitting and evaluation Materials		You pay any amount over the $250 allowance[6]	You pay any amount over $105 for fitting, evaluation and materials combined

You Don't Need a Prescription to Protect Your Eyes: With VSP LightCare, you can use your frame and lens benefit to get non-prescription eyewear, like sunglasses or blue light filtering glasses, whether from a VSP network doctor or an out-of-network provider. When using an out-of-network provider, you pay any amount over $70.

Note: Corrective eye surgery (e.g., Lasik) is covered under the Empire Medical Plans.

1 Service specific maximums (dollar and frequency) cross-accumulate between in-network and out-of-network unless otherwise noted.
2 Based on your last date of service.
3 Your plan provides a 20% discount on non-covered glasses and sunglasses when provided by a VSP doctor.
4 Patients may choose contacts in lieu of frames and lenses.
5 Medically necessary contact lenses must be prescribed for certain conditions that prevent you from wearing eyeglasses and must be pre-approved by VSP.
6 Your plan also includes a 15% discount off the cost of your contact lens exam (fitting & evaluation) when you receive contact lens services from a VSP doctor.

2023 Health Plan Comparison Summary

Dental Insurance

MetLife dental coverage may be selected independently of medical/vision coverage.

Dental Benefits	METLIFE (PDP DENTAL PLAN) METLIFE DENTISTS In-Network	NON-METLIFE DENTISTS Out-Of-Network
Annual Deductible (Calendar Year) Individual Family	$100 $200	
Preventive Care (twice per year) (Exams/Cleanings/X-rays)	No Charge	You pay 20% - No deductible applied
Dental Coinsurance		
Basic Restorative (e.g. fillings, extractions, root canals)	You pay 10%*	You pay 20%*
Major Restorative (e.g. crowns, bridges, implants)	You pay 40%*	You pay 50%*
Orthodontia (adults and children) Reimbursement is calculated based on Lifetime Maximum and payments are made on a quarterly basis throughout the length of orthodontic treatment	You pay 40% - No deductible applied	You pay 50% - No deductible applied
PLAN LIMITS		
Annual Dental Maximum (Calendar Year)	$3,000 per person	
Orthodontia Lifetime Maximum	$3,000 Lifetime Maximum per person	

Notes

All plan deductibles, plan out-of-pocket maximums, and service specific maximums (dollar and occurrence) cross-accumulate between in-network and out-of-network unless otherwise noted.

All out-of-network coinsurance levels referenced on this page are subject to MetLife's 'Allowed Amount', which refers to the maximum amount MetLife will pay for a covered service. If your out-of-network dental provider charges more than the Allowed Amount, you must pay the difference between the Allowed Amount and the actual charge. Amounts that are in excess of the Allowed Amount do not apply toward your annual deductible.

*These expenses are subject to the deductible.