Region 1 - 2nd Quarter 2024

Small Group Health Plan Comparison

GREENE COUNTY CHAMBER OF COMMERCE
SMALL EMPLOYER GROUP PLANS FOR 2ND QUARTER 2024

HMS Agency, Inc.
Insuring Today. Securing Tomorrow.

KAREN LANDAU AT HMS AGENCY, INC. KLANDAU@HMSAGENCY.COM

	2024 Option 1	2024 Option 2	2024 Option 3	2024 Option 4	2024 Option 5	2024 Option 6
Carrier	CDPHP	CDPHP	CDPHP	CDPHP	CDPHP	CDPHP
Product Type	EPO	EPO	HMO	EPO	HMO	EPO
Metal Tier	Gold	Gold	Gold	Gold	Silver	Bronze
Plan Name	Triple Zero EPO Copay (227) *NEW*	Embrace Health EPO Copayment (221) *$200 Bonus Account	Triple Zero HMO Copay (224)	EPO Copayment (220)	HDHMO Qualified (324)	HDEPO Qualified (421)
Networks	National	National	Local	National	Local	National
Aggregate / Embedded	N/A	Embedded	N/A	Embedded	Ded: AGG OOP: EMB	Embedded
HSA Qualified	No	No	No	No	Yes	Yes
Deductible (Single / Family)	None	$250 / $500 (EMB)	None	$750 / $1,500 (EMB)	$2,500 / $5,000 (AGG)	$7,050 / $14,100 (EMB)
Coinsurance	None	None	None	None	None	None
Out of Pocket Max (Single / Family)	$8,700 / $17,400	$9,100 / $18,200 (EMB)	$8,700 / $17,400 (EMB)	$8,700 / $17,400 (EMB)	$6,500 / $13,000 (EMB)	$7,050 / $14,100 (EMB)
PCP Office Visit	$0 EPC $50 Non EPC	Ded then $30	$0 EPC $50 Non EPC	Ded then $25	Ded then $25	Ded then Covered in Full
Specialist Visit	$50 Copay	Ded then $50	$50 Copay	Ded then $40	Ded then $50	Ded then Covered in Full
Labs (Outpatient)	$50 Copay waived at preferred lab	Ded then $50 Copay waived at preferred lab	$50 Copay waived at preferred lab	Ded then $40 Copay waived at preferred lab	Ded then $50 Copay waived at preferred lab	Ded then Covered in Full
X-Rays (Outpatient)	$50 Copay waived at preferred center	Ded then $50 Copay waived at preferred center	$50 Copay waived at preferred center	Ded then $40 Copay waived at preferred center	Ded then $50 Copay waived at preferred center	Ded then Covered in Full
Chemotherapy OP Facility	$50 Phys. Administered Meds: Copay then 20% (cost share applies to drug only)	Ded then $30 Phys. Administered Meds: Ded then 20%	$50 Phys. Administered Meds: Copay then 20% (cost share applies to drug only)	Ded then $25 Phys. Administered Meds: Ded then 20%	Ded then $25 Phys. administered meds: Ded then 20%	Ded then Covered in Full Phys. administered meds: Ded then Covered in Full
Radiation	$50 Phys. Administered Meds: Copay then 20% (cost share applies to drug only)	Ded then $30 Phys. Administered Meds: Ded then 20%	$50 Phys. Administered Meds: Copay then 20% (cost share applies to drug only)	Ded then $25 Phys. Administered Meds: Ded then 20%	Ded then $25 Phys. administered meds: Ded then 20%	Ded then Covered in Full Phys. administered meds: Ded then Covered in Full
Inpatient Surgery / Hospital	$1,500	Ded then $1,500	$1,500	Ded then $800	Ded then $500	Ded then Covered in Full
Outpatient Surgery / Facility	$200	Ded then $150	$200	Ded then $100	Ded then $200	Ded then Covered in Full
Emergency Room Visit	$500	Ded then $200	$500	Ded then $100	Ded then $300	Ded then Covered in Full
Urgent Care	$100	Ded then $70	$100	Ded then $60	Ded then $60	Ded then Covered in Full
Chiropractic	$50	Ded then $50	$50	Ded then $40	Ded then $50	Ded then Covered in Full
TeleMedicine	Preferred: Covered in Full Other Telemed Providers: $50 PCP/SPC: Cost share	Preferred: Covered in Full Other Telemed Providers: $30 PCP/SPC: Cost share	Preferred: Covered in Full Other Telemed Providers: $50 PCP/SPC: Cost share	Preferred: Covered in Full Other Telemed Providers: $25 PCP/SPC: Cost share	Preferred: Covered in Full Other Telemed Providers: $25 PCP/SPC: Cost share	Preferred: Ded then Covered in Full Other Telemed Providers: Ded then Covered in Full PCP/SPC: Cost share
Pediatric Dental	Yes - Additional Fee Applies If Applicable - See Below	Yes - Additional Fee Applies If Applicable - See Below	Yes - Additional Fee Applies If Applicable - See Below	Yes - Additional Fee Applies If Applicable - See Below	Yes - Additional Fee Applies If Applicable - See Below	Yes - Additional Fee Applies If Applicable - See Below
Pediatric Vision	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Adult Vision	Exam & Hardware: Every 12 Months	Exam & Hardware: Every 12 Months (after ded)	Exam & Hardware: Every 12 Months	Exam & Hardware: Every 12 Months (after ded)	Exam & Hardware: Every 12 Months (after ded)	Exam & Hardware: Every 12 Months (after ded)
Prescription Copay	$0 / $50 / $80	$10 / $50 / $80	$0 / $50 / $80	$4 / $30 / $60	Ded then $10 / $40 / $60 Preventive Not Subject to Ded	Ded then Covered in Full Preventive Not Subject to Ded
Out-of-Network Benefit	No out of network, but the National Network applies as IN network when using participating providers out of the area.	No out of network, but the National Network applies as IN network when using participating providers out of the area.	No	No out of network, but the National Network applies as IN network when using participating providers out of the area.	No	No out of network, but the National Network applies as IN network when using participating providers out of the area.
Medical Monthly Rates	2024 Rates	2024 Rates	2024 Rates	2024 Rates	2024 Rates	2024 Rates
Employee 1	$905.31	$899.35	$861.31	$899.51	$730.66	$678.10
Employee + Spouse 1	$1,810.62	$1,798.70	$1,722.62	$1,799.02	$1,461.32	$1,356.20
Employee + Child(ren) 1	$1,539.03	$1,528.90	$1,464.23	$1,529.17	$1,242.12	$1,152.77
Family 1	$2,580.13	$2,563.15	$2,454.73	$2,563.60	$2,082.38	$1,932.59
Pediatric Dental Rates	$16.49 per individual under age 19 (Up to 3 Per Family)	$16.49 per individual under age 19 (Up to 3 Per Family)	$16.49 per individual under age 19 (Up to 3 Per Family)	$16.49 per individual under age 19 (Up to 3 Per Family)	$16.49 per individual under age 19 (Up to 3 Per Family)	$16.49 per individual under age 19 (Up to 3 Per Family)

**This analysis is intended to provide a high level overview of coverage. In the event of any conflict between this analysis and the member's Certificate and any applicable Rider(s) issued by the carrier, the Certificate and Rider(s) will be the controlling documents.