Region 1 - 2nd Quarter 2024

Small Group Health Plan Comparison

GREENE COUNTY CHAMBER OF COMMERCE

SMALL EMPLOYER GROUP PLANS FOR 2ND QUARTER 2024 - HIGHMARK

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
Carrier		Highmark of NENY	Highmark of NENY	Highmark of NENY	Highmark of NENY	Highmark of NENY
Product Type		POS w/PPO WRAP	POS	POS w/PPO WRAP	POS w/PPO WRAP	POS
Metal Tier		Gold	Gold	Silver	Silver	Bronze
Plan Name		Gold High EX	Gold Radius High *Guest Membership	Silver 6300 EX	Silver 8000 EX	Bronze Value POS
Networks		Blue Card National Network	Local	Blue Card National Network	Blue Card National Network	Local
Aggregate / Embedded		Embedded	Embedded	Ded: AGG OOP: EMB	Embedded	Embedded
HSA Qualified		No	No	Yes	Yes	Yes
Deductible (Single / Family)		None	None	$2,500 / $5,000 (AGG)	$5,500 / $11,000 (EMB)	$7,500 / $15,000 (EMB)
Coinsurance		None	None	None	None	None
Out of Pocket Max (Single / Family)		$9,100/$18,200 (EMB)	$9,100 / $18,200 (EMB)	$7,500 / $15,000 (EMB)	$7,500 / $15,000 (EMB)	$7,500 / $15,000 (EMB)
Office Visit		$30 Copay	$30 Copay	Ded then $40	Ded then Covered in Full	Ded then Covered in Full
Specialist Visit		$50 Copay	$50 Copay	Ded then $60	Ded then Covered in Full	Ded then Covered in Full
Labs (Outpatient)		$50 Copay	$50 Copay	Ded then $60	Ded then Covered in Full	Ded then Covered in Full
X-Rays (Outpatient)		$50 Copay	$50 Copay	Ded then $60	Ded then Covered in Full	Ded then Covered in Full
Chemotherapy OP Facility		$30 / $50 Phys. Administered meds: Cost included in Copay	$30 / $50 Phys. Administered meds: Cost included in Copay	Ded then $40 / $60 Phys. Administered meds: Cost included in Ded / Copay	Ded then Covered in Full Phys. Administered meds: Cost included in Ded / Copay	Ded then Covered in Full Phys. Administered meds: Cost included in Ded / Copay
Radiation		$30 / $50 Phys. Administered meds: Cost included in Copay	$30 / $50 Phys. Administered meds: Cost included in Copay	Ded then $40 / $60 Phys. Administered meds: Cost included in Ded / Copay	Ded then Covered in Full Phys. Administered meds: Cost included in Ded / Copay	Ded then Covered in Full Phys. Administered meds: Cost included in Ded / Copay
Inpatient Surgery / Hospital		$1,000	$1,000	Ded then $1,000	Ded then Covered in Full	Ded then Covered in Full
Outpatient Surgery / Facility		$250	$250	Ded then $350	Ded then Covered in Full	Ded then Covered in Full
Emergency Room Visit		$300	$300	Ded then $250	Ded then Covered in Full	Ded then Covered in Full
Urgent Care		$75	$75	Ded then $75	Ded Then Covered in Full	Ded Then Covered in Full
Chiropractic		$30	$30	Ded then $40	Ded then Covered in Full	Ded then Covered in Full
TeleMedicine		Covered in Full	Covered in Full	Ded Then Covered in Full	Ded Then Covered in Full	Covered in Full
Pediatric Dental		Embedded see below	Embedded see below	Embedded see below	Embedded see below	Embedded see below
Pediatric Vision		Embedded	Embedded	Embedded	Embedded	Embedded
Adult Vision		Blue365 Vision Discount Program MUST be a Davis Vision Par Provider	Blue365 Vision Discount Program MUST be a Davis Vision Par Provider	Blue365 Vision Discount Program MUST be a Davis Vision Par Provider	Blue365 Vision Discount Program MUST be a Davis Vision Par Provider	Blue365 Vision Discount Program MUST be a Davis Vision Par Provider
Prescription Copay		$10 / $50 / $100 Preventive Enhanced Drug List	$10 / $50 / $100 Preventive Enhanced Drug List	Ded then $10 / $35 / $100 Preventive Enhanced Drug List	Ded then $10 / $35 / $100 Preventive Enhanced Drug List	Ded then Covered in Full
Out-of-Network Benefit		No out of network, but the National Network applies as IN network when using participating providers out of the area.	$5000/$10,000 Deductible, then 50% up to $10,000 / $20,000 annual out of pocket maximum.	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.	$5000/$10,000 Deductible, then 50% up to $10,000 / $20,000 annual out of pocket maximum.
Medical Monthly Rates		2024 Rates	2024 Rates	2024 Rates	2024 Rates	2024 Rates
Employee	1	$1,053.26	$999.99	$861.85	$814.48	$701.08
Employee + Spouse	1	$2,106.52	$1,999.98	$1,723.70	$1,628.96	$1,402.16
Employee + Child(ren)	1	$1,790.54	$1,699.98	$1,465.15	$1,384.62	$1,191.84
Family	1	$3,001.79	$2,849.97	$2,456.28	$2,321.27	$1,998.08
Pediatric Dental Rates		Rates embedded with monthly premium. Subject to any medical plan deductible.	Rates embedded with monthly premium. Subject to any medical plan deductible.	Rates embedded with monthly premium. Subject to any medical plan deductible.	Rates embedded with monthly premium. Subject to any medical plan deductible.	Rates embedded with monthly premium. Subject to any medical plan deductible.

**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.