Region 1 -1st Quarter 2025
Small Group Health Plan Comparison

GREENE COUNTY CHAMBER OF COMMERCE

2nd QUARTER 2025 CDPHP Plan Options

HMS Agency, Inc.
Insuring Today. Securing Tomorrow.

KAREN LANDAU AT HMS AGENCY, INC.	New Plan Option 1	New Plan Option 2	New Plan Option 3	New Plan Option 4	New Plan Option 5	New Plan Option 6
Carrier	CDPHP	CDPHP	CDPHP	CDPHP	CDPHP	CDPHP
Product Type	EPO	EPO	HMO	HMO	HMO	HMO
Metal Tier	Platinum	Gold	Gold	Silver	Silver	Bronze
Plan Name	EPO Copayment (130)	Triple Zero EPO Copay (227)	Triple Zero HMO Copay (224)	HDHMO Qualified (327)	Copay First HMO ($3,000/$6,000) (427)	HDHMO Non Qualified (426)
Networks	National	National	Local	Local	Local	Local
Aggregate / Embedded	N/A	N/A	N/A	Ded: AGG OOP: EMB	Embedded	Embedded
HSA Qualified	No	No	No	Yes	No	No
Deductible (Single / Family)	$0 / $0	N/A	N/A	$2,200 / $4,400 (AGG)	Phase 1: $3,000 / $6,000 (AGG) (Cost Share/not ded) Phase 2: $6,000 / $12,000 (EMB)	$8,550 / $17,100 (AGG)
Coinsurance	0%	0%	0%	0%	0%	20%
Out of Pocket Max (Single / Family)	$4,000 / $8,000 (EMB)	$8,700 / $17,400	$8,700 / $17,400 (EMB)	$7,050 / $14,100 (EMB)	$6,000 / $12,000 (EMB)	$8,550 / $17,100 (EMB)
PCP Office Visit	$15 Copay	$0 EPC $50 Non EPC	$0 EPC $50 Non EPC	Ded then $30	Phase 1: $30 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Specialist Visit	$35 Copay	$50 Copay	$50 Copay	Ded then $40	Phase 1: $50 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Labs (Outpatient)	$35 Copay waived at preferred lab	$50 Copay waived at preferred lab	$50 Copay waived at preferred lab	Ded then $40 Copay waived at preferred lab	Phase 1: $50 / Phase 2: Ded then Covered in Full Copay waived at preferred lab	Ded then Covered in Full
X-Rays (Outpatient)	$35 Copay waived at preferred center	$50 Copay waived at preferred center	$50 Copay waived at preferred center	Ded then $40 Copay waived at preferred center	Phase 1: $50 / Phase 2: Ded then Covered in Full Copay waived at preferred center	Ded then Covered in Full
Chemotherapy OP Facility	$15 Phys. Administered Meds: Copay then 20%	$50 Phys. Administered Meds: Copay then 20% (cost share applies to drug only)	$50 Phys. Administered Meds: Copay then 20% (cost share applies to drug only)	Ded then $30 Phys. Administered Meds: Ded then 20%	Phase 1: $30 / Phase 2: Ded then Covered in Full Phys. Administered Meds: Phase 1: 20% / Phase 2: Ded then Covered in Full	Ded then Covered in Full Phys. Administered Meds: Ded then 20%
Radiation	$15 Phys. Administered Meds: Copay then 20%	$50 Phys. Administered Meds: Copay then 20% (cost share applies to drug only)	$50 Phys. Administered Meds: Copay then 20% (cost share applies to drug only)	Ded then $30 Phys. Administered Meds: Ded then 20%	Phase 1: $30 / Phase 2: Ded then Covered in Full Phys. Administered Meds: Phase 1: 20% / Phase 2: Ded then Covered in Full	Ded then Covered in Full Phys. Administered Meds: Ded then 20%
Inpatient Surgery / Hospital	$500	$1,500	$1,500	Ded then $1,500	Phase 1: $500 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Outpatient Surgery / Facility	$100	$200	$200	Ded then $200	Phase 1: $100 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Emergency Room Visit	$100	$500	$500	Ded then $500	Phase 1: $75 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Urgent Care	$60	$100	$100	Ded then $60	Phase 1: $60 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Chiropractic	$35	$50	$50	Ded then $40	Phase 1: $50 / Phase 2: Ded then Covered in Full	Ded then Covered in Full
TeleMedicine	Preferred: Covered in Full Other Telemed Providers: $15 PCP/SPC: Cost share	Preferred: Covered in Full Other Telemed Providers: $50 PCP/SPC: Cost share	Preferred: Covered in Full Other Telemed Providers: $50 PCP/SPC: Cost share	Preferred: Covered in Full Other Telemed Providers: $30 PCP/SPC: Cost share	Phase 1: Preferred: Covered in Full Other Telemed Providers: $30 PCP/SPC: Cost Share Phase 2: Ded then Covered in Full	Preferred: 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	Exam & Hardware: Every 12 Months	Exam & Hardware: Every 12 Months (after ded)	Exam & Hardware Phase 1: $30 Phase 2: Ded then Covered in Full	Exam & Hardware: Every 12 Months (after ded)
Prescription Copay	$4 / $30 / $60 50% cost share for non pref pharmacy	$0 / $50 / $80 50% cost share for non pref pharmacy	$0 / $50 / $80 50% cost share for non pref pharmacy	Ded then $10 / $50 / $80 Preventive Not Subject to Ded 50% cost share for non pref pharmacy	Phase 1: $10 / $30 / $50 Phase 2: Ded then Covered in Full 50% cost share for non pref pharmacy	Ded then Covered in Full Preventive Not Subject to Ded 50% cost share for non pref pharmacy
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	No	No
Medical Monthly Rates	2025 Rates	2025 Rates	2025 Rates	2025 Rates	2025 Rates	2025 Rates
Employee	$1,283.40	$1,091.88	$983.74	$827.29	$827.32	$686.93
Employee + Spouse	$2,566.80	$2,183.76	$1,967.48	$1,654.58	$1,654.64	$1,373.86
Employee + Child(ren)	$2,181.78	$1,856.20	$1,672.36	$1,406.39	$1,406.44	$1,167.78
Family	$3,657.69	$3,111.86	$2,803.66	$2,357.78	$2,357.86	$1,957.75
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.